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States as Contractor

Attempts to Drive Health Care Cost Containment through State Purchasing Power

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6.1 INTRODUCTION

US health care costs are spiraling upwards, largely because of the high and rising prices set by hospitals and other health care providers. Commercial insurers and large employers mostly pass along these high prices to consumers in the form of increased premiums and cost-sharing, leaving many Americans financially unstable. Yet political and practical barriers block reforms that seek to limit provider prices via regulation. To circumvent these barriers, several states are leveraging their role as contracting entities and players in the private health care market to further public policy goals, such as controlling health care costs.

These government engagements in the private market fall somewhere along the porous border between private and public law. In the types of contracting relationships we discuss here, we posit that the state functions as a de facto private actor. While some might argue that the state can never function as a private actor, given its outsized power and the complex body of government contracting laws set up to protect its rights, we find that the similarities between the state as a private actor and large, fully privately owned, corporations are greater than the differences between them. Large corporations similarly bring their significant, sometimes monopolistic, power to bear in negotiating their contracts, and leverage centuries-old commercial laws to enforce those contracts. Both types of entities use their market position and legally provided protections to work toward their ultimate goals, which in the case of privately owned entities is profit, and in the case of state actors is the advancement of public policy goals such as saving taxpayer dollars or making health care affordable.

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In this chapter, we explore three examples of states turning to different types of typically private roles to try to lower commercial health care costs. First, we discuss how states can leverage their role as marketplace operators, like Amazon or Apple (vis a vis the "App" Store), to serve as a conduit between sellers and purchasers of insurance. This role allows states to engage in selective contracting practices with insurer-sellers to drive down premiums and drive up the value of the products offered on the marketplace. This is a tactic many envisioned as a best practice for marketplaces created under the Affordable Care Act (ACA). Second, we will turn to recent efforts by states like Washington to newly enter the private health insurance market by enacting public health insurance options in partnership with private health insurers. These efforts are also intended to bring to the market more high-value, low-cost insurance products to consumers. Third, we will examine how some states leverage their long-standing role as purchasers of health insurance to achieve cost containment. States, like most large, private employers, provide health insurance to their workers, retirees, and their dependents through employee health plans, and in any given state, the state employee health plan (SEHP) is one of the largest, if not the largest, purchasers of health benefit services from commercial insurers, who act as third-party administrators.

States have seen varying degrees of success and encountered different barriers, when engaging with the health insurance market in these three different roles. Other analyses of states engaging in the private market often focus on the merits of privatizing public programs and functions to reduce the size and scope of government and how these efforts risk the watering down of legal rights, remedies, and other protections for beneficiaries.[1] By contrast, our examples allow "agencies [to] extend their influence to matters and actors that they could not otherwise lawfully reach" and shape the market to achieve public interest goals.[2] Despite their promise, however, we find that market-driven reforms can only do so much when the marketplace is already as broken as the US health care system is. Nonetheless, they can still serve as intermediate steps on the way to a better-functioning health care market pending broader reforms to our health care delivery and payment systems.

6.2 ROADBLOCKS TO CONTAINING HEALTH CARE COSTS

The United States spends about twice as much as other high-income countries on health care, while performing relatively poorly on population health outcomes.[3]

[1] See, e.g., David A. Super, Privatization, Policy Paralysis, and the Poor, 96 Calif. L. Rev. 393 (2008); Gillian E. Metzger, Privatization as Delegation, 103 Colum. L. Rev. 1367, 1376–400 (2003); Jody Freeman, The Contracting State, 28 Fla. St. U. L. Rev. 155, 176–88 (2000).

[2] Jody Freeman, The Private Role in Public Governance, 75 N.Y.U. L. Rev. 543, 671 (2000).

[3] Irene Papanicolas et al., Health Care Spending in the United States and Other High-Income Countries, 319 JAMA 1024, 1024 (2018).

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These high costs are not driven by US patients using more services or the United States providing particularly high-quality care. Instead, they largely stem from the prices commercial insurers pay for hospital and physician services.[4]

Commercial insurers and group health plans in the United States pay for the health care of about 177 million people, and they pay significantly more than public insurers like Medicare and Medicaid for the same services.[5] In response to rising health care prices, these payers have shifted more of the cost burden to plan enrollees through higher premiums and out-of-pocket costs.[6] Given their ability to shift costs and market pressures to maintain good relationships with health care providers, commercial insurers have little incentive to negotiate lower prices with providers, and may in fact have an incentive to inflate spending because their profits are tied to a percentage of premiums collected (in the fully insured markets, due to federal medical loss ratio requirements) or claims paid (in self-insured markets, where insurers are administering plans funded by employers and employees).[7]

Insurers' insufficient incentive to negotiate lower prices, combined with rapid provider market consolidation, has given health care providers outsized leverage when contracting with insurers, and made it unlikely for the existing commercial insurance market to achieve meaningful cost containment absent government intervention. In response, experts and policymakers have debated a range of regulatory strategies to try and contain costs in the commercial sector and have largely reached the same conclusion: "the only solution that may be effective in a concentrated provider market is regulation of health care prices."[8] Yet few states currently regulate commercial health care prices and, with the exception of Maryland, efforts that have been made have generally been indirect (e.g., setting cost growth benchmarks) or narrowly focused (e.g., preventing "surprise" billing by out-of-network providers).[9] In the 1970s and 1980s, many more states directly regulated prices, but

[4] Gerard F. Anderson et al., It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt, 38 Health Affs. 87, 93 (2019).

[5] Cong. Budget Off., Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services 1 (2022), https://www.cbo.gov/publication/58222.

[6] Gary Claxton et al., Employer Health Benefits: 2023 Annual Survey, Kaiser Family Found. 90–91, 111–14, 132–34 (2023), https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.

[7] Inside Big Health Insurers' Side Hustle, Tradeoffs (Sept. 23, 2021), https://tradeoffs.org/2021/09/23/inside-big-health-insurers-side-hustle/; Marshall Allen, Why Your Health Insurer Doesn't Care about Your Big Bills, Nat'l Pub. Radio (May 25, 2018, 5:00 AM), https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills.

[8] Erin C. Fuse Brown, Resurrecting Health Care Rate Regulation, 67 Hastings L.J. 85, 128–29 (2015).

[9] Provider Rate Regulation, The Source on HealthCare Price and Competition (May 2023), https://sourceonhealthcare.org/provider-rate-regulation/; Linda J. Blumberg et al., Can Employer-Sponsored Insurance Be Saved? A Review of Policy Options: Price Regulation, CHIRblog (Jan. 18, 2023), https://chirblog.org/can-esi-be-saved-review-of-policy-options-price-regulation/.

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this fell out of favor for many interconnected reasons, including the general philosophical and political shift toward market-based mechanisms in the 1990s and the advent of managed care organizations promising to control costs via internal mechanisms.[10]

Renewed efforts to meaningfully regulate health care costs have failed largely due to political barriers.[11] The hospital industry holds significant political power and strongly opposes price regulation.[12] Because the insurance industry also profits from higher health spending, their interests are aligned.[13] Many policymakers also prefer a lighter regulatory touch, pushing back against government actions that can be seen as unduly affecting market dynamics.[14] When implemented, even narrow regulatory reforms face legal challenges and obstruction from industry.[15]

Given these obstacles, policymakers are turning to reforms that make use of government purchasing power and contracting tools, as more politically attractive and easier to implement. We explore three examples of states leveraging their contracting authority and purchasing power, rather than their regulatory authority, to lower health care costs in the private health insurance market. Although the reach of these reforms is narrower than traditional regulatory reforms, we explore the extent to which states can use them to effect incremental change while waiting for political winds to return in favor of price regulation.

6.3 WIELDING A LIGHTER TOUCH: CAN STATES CONTRACT TO LOWER HEALTH CARE PRICES?

6.3.1 *Health Insurance Marketplaces*

A health insurance exchange or marketplace is a state-operated one-stop shop where consumers or businesses can compare and enroll in health insurance products. The marketplace serves as the key connection point between insurance plans and consumer purchasers, similar to how Apple's iTunes store connects artists looking to sell their music with fans looking to purchase it. And, just as Apple separately

[10] Provider Rate Regulation, supra note 9; Len M. Nichols et al., Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning, 23(2) Health Affs. 8 (2004); Gail B. Agrawal & Howard R. Veit, Back to the Future: The Managed Care Revolution, 65(4) Law & Contemp. Probs. 11 (2002).

[11] Fuse Brown, supra note 8, at 138.

[12] Rachel Cohrs, The Health Care Issue Democrats Can't Solve: Hospital Reform, STAT News (Oct. 26, 2023), https://www.statnews.com/2023/10/26/the-health-care-issue-democrats-cant-solve-hospital-reform.

[13] See Allen, supra note 7; Katie Keith, Insurer Accountability in the Next Generation of Health Reform, 15 St. Louis U. J. Health L. & Pol'y 331, 339–40 (2022).

[14] See, e.g., Joseph Antos & James C. Capretta, The Road Not Taken, in The Trillion Dollar Revolution 66, 71–72 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020).

[15] See generally Timothy Stoltzfus Jost & Katie Keith, ACA Litigation: Politics Pursued through Other Means, 45 J. Health Pol., Pol'y, & Law 485 (2020).

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contracts with music artists before they can sell music on iTunes, the state enters into contracts with private health insurers seeking to sell their plans through the state-run exchanges. Experts envisioned that states would engage in a practice known as "active purchasing," and negotiate with several insurers to extract better insurance products and lower rates for the products that eventually end up on the marketplace.[16] States and employers can achieve this by employing selective contracting practices, such as competitive bidding and negotiation processes, to advance goals like cost containment. By requiring private insurers to compete against each other to earn the ability to participate in the marketplace, these practices harness traditional forces of market competition to nudge private actors to provide a more robust product. If the marketplace is not attractive to insurers, however, they can opt out and offer their plans to consumers off-marketplace.

The first successful active-purchasing marketplace was established by the Massachusetts Connector Authority in 2006. The Authority created a system of two separate marketplaces: Commonwealth Care for low-income individuals who qualify for state-funded subsidies, and Commonwealth Choice for non-state-subsidized individuals and small businesses. By making Commonwealth Care the sole source of state subsidies, Massachusetts could create a "captive" market, with all subsidy-eligible consumers incentivized to participate in Commonwealth Care rather than shopping elsewhere and paying full price.[17] This captive market encouraged insurer participation. As a result, the state had enough insurers wanting to participate that it was able to selectively contract with insurers. The Connector authority also structured marketplace rules to encourage lower bids from insurers: for example, automatically enrolling participants who signed up but failed to choose a plan in the lowest-cost option, and administering risk-sharing to protect plans against the risks of enrolling disproportionally expensive enrollees.[18] These decisions resulted in annual premium increases with half the growth rate of private insurance.[19]

Massachusetts served as a model for federal lawmakers designing the ACA, but ten years into implementation of the ACA marketplaces, California is the only other state to take similarly aggressive measures. Marketplace officials report that they "extract[] concessions on price and product design as a condition for having access to the largest pool of new enrollees in the state" and have "excluded plans that have

[16] Sabrina Corlette & JoAnn Volk, Active Purchasing for Health Insurance Exchange: An Analysis of Options, Nat'l Acad. Soc. Ins. 4 (June 2011), https://www.nasi.org/wp-content/uploads/2011/06/Active_Purchasing_for_Health_Insurance_Exchanges.pdf (quoting Alain C. Enthoven, The History and Principles of Managed Competition, 12 Health Affs. 24, 29 (Supp. 1993)).

[17] Id. at 7.

[18] Sabrina Corlette et al., The Massachusetts and Utah Health Exchanges: Lessons Learned, Georgetown Univ. Health Pol'y Inst. Ctr. for Children and Families (Mar. 2011), https://ccf.georgetown.edu/wp-content/uploads/2012/03/Health-reform_exchanges.pdf.

[19] Id.

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not demonstrated the administrative capability, prices, networks, or product designs that improve consumer value."[20] Additionally, the marketplace "jawbones down premiums to the extent it can, leveraging its private information on risk mix, competitor rates, and the price elasticity of demand."[21] Studies suggest that these reforms have had a positive effect on the individual market. California's premiums have grown more slowly than national averages, marketplace enrollment is one of the highest in the country, and statewide average risk scores have been in the bottom 10 percent of states each year for both on-and-off marketplace plans.[22]

Some other state marketplaces and the federal marketplace have taken more cautious approaches, primarily focused on improving the quality and adequacy of coverage by requiring insurers to agree to certain minimum standards as a condition of marketplace participation. But these marketplaces have been reluctant to push for lower premiums using the best tool available to them – selective contracting with those insurers offering the most competitive rates or engaging in California-style "jawbone" negotiations.

There are several explanations for this hesitancy. In some states, proponents of limited government object to states employing these contracting tactics because they perceive it as the state controlling insurer access to the marketplace – Colorado explicitly prohibits their marketplace from "solicit[ing] bids or engag[ing] in the active purchasing of insurance."[23] Some experts also have argued that states cannot justify the expenditure of resources required to engage in active purchasing, since they do not foot the cost of premiums.[24] Market dynamics, including increasing insurer consolidation, likely play the biggest role, however.

Few insurers participated in the individual and small group markets served by ACA marketplaces, when the law was passed. To encourage greater insurer participation while simultaneously increasing the minimum standards insurers must meet to serve these markets, the ACA provided federal financial assistance only to consumers who purchase coverage through the marketplaces and established risk adjustment and reinsurance programs to minimize adverse selection. Despite these efforts, individual and small group markets continue to be largely dominated by a small number of insurers. This leaves most marketplaces with little leverage to

[20] James C. Robinson et al., Whither Health Insurance Exchanges under the Affordable Care Act? Active Purchasing versus Passive Marketplaces, Health Affs. Forefront (Oct. 2, 2015), https://www.healthaffairs.org/content/forefront/whither-health-insurance-exchanges-under-affordable-care-act-active-purchasing-versus.

[21] Id.

[22] Al Bingham et al., National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success, Health Affs. Forefront (July 11, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20180710.459445/full/.

[23] Colo. Rev. Stat. § 10-22-104.

[24] See, e.g., William Kramer, Why Aren't State Exchanges Embracing Prudent Purchasing Strategies?, Health Affs. Forefront (Mar. 19, 2012), https://www.healthaffairs.org/content/forefront/why-aren-t-state-exchanges-embracing-prudent-purchasing-strategies. This rationale, however, does not apply to states funding subsidies that supplement federal financial assistance.

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threaten to exclude one or more insurers in a bidding or negotiation process. Even in states with relatively unconsolidated insurer markets, marketplaces can be hesitant to restrict consumer choice – "the bedrock of the American economy and, increasingly, of the American health economy"[25] – in the name of cost containment. A marketplace with just one or two insurers may struggle to compete with less-regulated and cheaper plans offered outside the marketplace to attract consumers, especially those who do not qualify for significant marketplace subsidies.

In order for states to be able to follow Massachusetts' and California's leads to fully exert the powers of private law and extract lower premiums, they must (1) remove any barriers preventing marketplaces from using the full arsenal of contractual tools available to them and (2) push against the forces of consolidation that are throttling the performance of the health insurance market. One such mechanism is our next example of states increasing competition in the private market in nontraditional ways: by establishing a new state public health insurance option to compete against private insurers' products.

6.3.2 *Market-Based Public Options*

Traditionally, a public option is a publicly insured health plan that competes against private insurers. With these plans, the state is engaging in the private market itself and subject to the same rules as a private insurer. However, because the government controls provider reimbursement rates and lacks a profit motive, public option plans can be a tool to lower health care costs and expand coverage, while expanding consumer choice.

No such plan exists today, albeit not for lack of trying; these proposals have faced steep practical barriers. Establishing and financing a new health insurance plan is no small endeavor, particularly for budget-strapped state governments. Like other cost containment reforms, public option proposals garner significant opposition from industry groups seeking to preserve the status quo, and activists and legislators hoping to minimize government involvement in health care. Nonetheless, two states – Washington and Nevada – have enacted laws authorizing the state to contract with private insurers to offer new "Market-Based Public Options" (MBPOs), advancing state cost containment and other policy goals without the government directly taking on the financial and administrative burden of operating a health insurance plan.[26]

[25] Robinson et al., supra note 20.

[26] See Jaime S. King et al., Are State Public Option Health Plans Worth It, 59 Harv. J. on Legis. 145, 150–51, 166–68, 174–77 (Winter 2022); Christine Monahan et al., State Public Option-Style Laws: What Policymakers Need to Know, Commonwealth Fund (July 23, 2021), https://www.commonwealthfund.org/blog/2021/state-public-option-style-laws-what-policymakers-need-know. Colorado also has implemented a quasi-public option law, but it legally requires all insurers to offer "Colorado Option plans" that meet statutory premium reduction targets, and, if

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To effectuate these MBPOs, states must get the insurers and providers that vehemently opposed enactment of these programs to participate. And because these plans are starting with no covered lives, states cannot woo insurers or providers with the promise of a large volume of enrollees. Although states could use their regulatory power to simply mandate participation, both Washington and Nevada have instead sought to leverage their purchasing power to encourage insurers and providers to participate, more akin to how a private company may engage with suppliers. Of the two, Washington warrants the closest consideration; its program has been in operation for three years while Nevada's remains in the planning stages.

Washington's initial approach to both insurer and provider participation was purely voluntary: The state imposed no explicit incentives or disincentives for insurers to offer MBPOs or providers to join MBPO networks. Although several insurers (including two new entrants to the marketplace) successfully bid to contract with the state, providers largely declined to join MBPO networks, resulting in limited MBPO availability. This was most likely because MBPOs cap aggregate provider payments at no more than 160 percent of Medicare reimbursement rates as its primary method of containing costs, while imposing no explicit cost reduction obligations on insurers.

To improve provider participation in subsequent years, Washington leveraged its market power and required providers that (voluntarily) participate in other state health insurance programs, including Medicaid, to join at least one MBPO network. While lawmakers were told this would have the same effect as a mandate, the legal and political optics may have been more palatable, as providers ultimately maintained a choice of whether or not to participate in state-aligned programs.[27] Indeed, this tactic is akin to how many private actors engage in health care markets (albeit subject to criticism as anticompetitive). For example, large health systems commonly negotiate all-or-nothing contracts with insurers, where the insurer must contract with all providers within the system or none at all. Washington's tying requirement helped expand MBPO plan availability and enticed more insurers to bid to offer MBPO plans. The increased competition even allowed Washington to selectively contract with just a subset of insurers that offered the best mix of geographic reach and lower premiums.

Washington's MBPOs are increasingly becoming the lowest premium options in the marketplace, but they still have not been able to achieve significant premium

these targets are not met, authorizes the state to administratively order health care providers to participate in Colorado Option plan networks at state-imposed reimbursement rates. See Monahan et al.

[27] Off. of Fin. Mgmt. (Wash. State), Multiple Agency Fiscal Note Summary: 5377SB, 3 (2021), https://fnspublic.ofm.wa.gov/FNSPublicSearch/GetPDF?packageID=62340. An earlier version of the bill amending Washington's public option law would have required certain hospitals systems to contract with at least one MBPO. See S. Rep. SB 5377, at 5–6 (Wash. Feb. 22, 2021), https://lawfilesext.leg.wa.gov/biennium/2021–22/Pdf/Bill%20Reports/Senate/5377%20SBR%20WM%20OC%2021.pdf?q=20211031060456.

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reductions and enrollment remains low. Looking ahead, market dynamics – and the political choices that shape them – will continue to affect how well Washington's public option program will be able to reduce costs. The biggest test may be whether the MBPOs can attract consumers in substantial numbers while keeping prices in check. As with marketplaces, the American preference for choice may limit how much costs can be constrained with private market tools alone: Current MBPO plan networks are narrower than their competition, which has allowed insurers to negotiate lower reimbursement rates by promising greater volume to the limited number of in-network providers. But consumers may prefer to maintain their choice of provider or hospital even if it means paying more. Washington and other states implementing or considering MBPOs have to tread carefully and find the right balance between making the products competitive in the market and achieving cost containment.

6.3.3 *State Employee Health Plans*

State Employee Health Plans present one of the biggest opportunities for states to contain health care costs by engaging with, rather than regulating, the market. State employee health plans have significant purchasing power: State and local governments are frequently the biggest employer in a given state and administer an employee benefit program. State employee health plans also have a direct interest in reducing spending on employees' health care services – amplified by the frequent threat of state budget cuts. But unlike other employer health plans, SEHPs often cannot achieve cost savings by shifting costs to their employees, due to legal and practical constraints.

State employee health plans contract with private insurers – either as a third-party administrator (TPA) or insurer – and these private insurers, in turn, negotiate rates with health care providers. The dynamics between these parties affect the success of any cost-containment initiative. Some SEHPs have leveraged their purchasing power in negotiations with both providers and TPAs to promote cost containment. For example, in 2016, Montana SEHP administrators used their purchasing power to cap what they would pay for hospital services at 234 percent of Medicare rates,[28] which saved the state about US$47.8 million over three years.[29] Additionally, at least fourteen states have leveraged their vendor procurement process to "extract[] performance guarantees and hold[] TPAs accountable to cost

[28] Julie Appleby, "Holy Cow" Moment Changes How Montana's State Health Plan Does Business, Kaiser Health News (June 20, 2018), https://khn.org/news/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/.

[29] Adney Rakotoniaina, Overview of States' Hospital Reference-Based Pricing to Medicare Initiative, Nat'l Acad. for State Health Pol'y (Oct. 19, 2021), https://nashp.org/overview-of-states-hospital-reference-based-pricing-to-medicare-initiatives/.

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containment goals."[30] For example, one study reports that a state implemented a "reverse auction" strategy when soliciting bids from their TPAs, sharing information about bids received with all competing vendors to encourage better offers in subsequent bidding rounds. The study finds that this state succeeded in lowering prices and increasing cost transparency.[31] These reforms have been possible because SEHPs' captive enrollee population draws both providers and insurers to the negotiating table.

Cost-containment efforts by state administrators have been rare, however. In many cases, SEHPs are limited by their need for state legislative approval to pursue these types of cost-containment strategies, opening the door to industry opposition that can kill reform efforts or create loopholes.[32] For example, the New Jersey SEHP has legislative authority to use the above-mentioned "reverse auctioning" procurement strategy to get concessions from its pharmacy benefit managers, but not its TPAs.[33]

Even when legislative authority is not a barrier, SEHPs still face an uphill battle when implementing reforms. State employee health plans are entrenched in decades-old traditions and policies, making it difficult for policymakers and many SEHP administrators to see SEHP agencies as agents of reform. State employee health plan administrators have limited resources at their disposal compared to other large private purchasers. Developing cost containment initiatives can be resource intensive: states that have tried to develop innovative provider payment models, like episode-based or bundled payments, have described it as "a ton of work."[34] Third-party administrators have also made it difficult for SEHPs to access and use their own claims data, a prerequisite for developing new cost-containment initiatives. Even when the data is available, many SEHPs lack the staffing and funding to adequately analyze it.

And, as with our other examples, market consolidation and consumer preferences also significantly limit SEHPs' negotiating power. Public employees expect generous benefit packages with broad provider networks and eye efforts to contain costs with skepticism, viewing money saved as a benefit that accrues to the state, not to them directly. Provider consolidation exacerbates this problem, as employees do not want to lose access to a dominant health system, tying the plan's hands when negotiating rates with providers. Similarly, states with a dominant insurer cannot

[30] Sabrina Corlette et al., Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability, Ctr. on Health Ins. Reforms 22 (June 2021), https://sehpcostcontainment.chir.georgetown.edu/documents/SEHP-report-final.pdf.

[31] Id. at 23.

[32] See, e.g., Adney Rakotoniaina, How Oregon Is Limiting Hospital Payments and Cost Growth for State Employee Health Plans, Nat'l Acad. for State Health Pol'y (Aug. 30, 2021), https://nashp.org/how-oregon-is-limiting-hospital-payments-and-cost-growth-for-state-employee-health-plans/.

[33] Corlette et al., supra note 30, at 23.

[34] Id. at 15.

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afford to lose access to their current TPA, making it difficult to fully leverage the state procurement process to reduce costs. Dominant providers and TPAs can also wield considerable political influence and financial resources. For example, North Carolina's SEHP recently conducted a transparent and thorough process requesting proposals for a TPA, and selected Aetna instead of Blue Cross and Blue Shield of North Carolina (Blue Cross NC), which had been the TPA for over forty years.[35] Blue Cross NC is now directing significant resources toward trying to get this decision overturned.[36]

Despite the barriers, given their captive market and relative size, SEHPs remain an opportunity for states looking to experiment with cost-containment initiatives without generating the political opposition inherent in the legislative process.

6.4 STATE CONTRACTING AS A STOPGAP: HOLDING THE LINE FOR BROADER REFORMS

Implementing effective cost-containment reforms is an immense challenge. Above, we have shared examples of how a handful of states have leveraged their role as private actors and contracting entities to advance this goal. While regulatory efforts to control prices largely remain politically infeasible, these examples offer a potential path forward. However, these state contractual approaches are not a panacea.

Despite working within a private law framework governed by market forces, state contractual and market-based approaches to cost containment can be seen as being closely intertwined with exercises of legislative and regulatory authority. Indeed, state actors frequently require legislative authorization to use their market power, and this opens the door to opposition. Even though these strategies mirror those private actors commonly use, proponents of "free market principles" or small government may reject these efforts as a proxy for government regulation or fail to adequately fund state agencies to effectively implement them. Perhaps even more detrimentally, these efforts face opposition from well-funded industry actors who no more wish to feel meaningful competitive or market pressure from the government than regulation.

Nonetheless, experience to date suggests contractual approaches carry a much lower risk of legal challenge and obstruction than direct price regulation, and SEHP reforms appear to have particular support from conservative policymakers.[37]

[35] Theresa Opeka, Appeals from BCBSNC & UMR, Inc. Rejected by NC State Health Plan, Carolina J. (Jan. 20, 2023), https://www.carolinajournal.com/appeals-from-bcbsnc-umr-inc-rejected-by-nc-state-health-plan/.

[36] C. J. Staff, Blue Cross NC Takes State Health Plan Decision to Court, Carolina J. (Feb. 16, 2023), https://www.carolinajournal.com/blue-cross-nc-takes-state-health-plan-decision-to-court/.

[37] See Brian C. Blase, Demonstrate Leadership: Reform the State Employee Health Plan, in Don't Wait for Washington: How States Can Reform Health Care Today 9–20 (Brian C. Blase ed., 2021).

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The more profound limitations on contractual approaches to cost containment is consolidation in US health care markets combined, perhaps ironically, with an intense desire to preserve consumer choice. Often the government does not have meaningful bargaining power because there are only one or two dominant insurers and/or health systems in the market. The consolidation in the health care market is resulting in a market failure, where prices and premiums keep increasing, and anticompetitive practices are rampant. Even when the market is not heavily consolidated, policymakers remain hesitant to leverage their negotiating power and exclude higher-cost options and thereby limit consumer choice. That a "faith in … consumer choice"[38] can hijack cost containment efforts is only made more questionable by the fact that consumers, universally, struggle to make informed, rational health care decisions.

This conclusion brings us back to where many economists and policy experts started: If consumer choice and market power cannot achieve meaningful price controls, then comprehensive rate regulation may be in order. But if the opportunity arises, states may want to try the mechanisms discussed, here, while Congress debates broader federal reforms. US health care reform has tended to be a story of incrementalism, and experiences like selective contracting by the Massachusetts and California health insurance marketplaces, introduction of a market-based public health insurance option by Washington, and Montana's experimentation with capping provider reimbursement can serve as precursors to more significant changes. Under the right circumstances, these policies benefit enrollees and can even have modest spillover effects. In acting now with the tools available, states can not only benefit themselves but lay the groundwork and show support for Congress to tackle health care costs nationally.

[38] Martha Minow, Public and Private Partnerships: Accounting for the New Religion, 116 Harv. L. Rev. 1229, 1230 (2003).

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