

Bipartisan Approaches to Tackling Health Care Costs at the State Level

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Executive Summary

Health care costs are one of the most pressing policy issues of our time and are perhaps even more important in the coronavirus era, when state and many family budgets are deeply stretched. Yet conversations about health care costs are often unproductive, as people talk past one another and use the same words to mean different things. For instance, some use “costs” to mean costs borne by individuals, such as premiums and deductibles, whereas others use “costs” to represent costs to providers, insurers, hospitals, or the government. Developing a shared understanding of what we mean when we talk about health care costs—and which issues need to be solved—are the critical next steps toward developing consensus on solutions.

We surveyed state legislators across the country and conducted case-study interviews in four states (Colorado, Michigan, South Carolina, and Vermont) to understand their health policy priorities, how they think about health care costs, and how to have a more productive conversation about solutions. Our research suggests that there is more opportunity for bipartisan agreement than many realize.

This report highlights six key findings. First, in many states there are effectively three parties, not two. Although many legislators fit best into groups that are predominantly Democratic or predominantly Republican, about a third fit better in a third group comprising moderates from each party. It’s noteworthy that Republicans in this third group say that reducing the role of government is a low priority. A coalition of such moderates is bridging divides on health care costs even in states with intense partisan splits, like Michigan.

Second, which health-care-cost priorities legislators are focused on—for example, high premiums for individuals or the budget impact of rising costs on states—is *not* particularly partisan. This finding of a nonfinding is at first glance frustrating but might actually be *good* news. It suggests that people’s understanding of what they mean by “health care costs” is not hard-wired or ideological. As a case in point, our third finding is that all legislators placed a high priority on pharmaceutical costs.

Fourth, legislators still bring a partisan lens to the conversation about *solving* health care costs even if they do not think of the cost *drivers* in partisan terms. Legislators in the predominantly Republican group tended toward solutions focused on the impact of high costs on individuals, whereas Democrats and moderates from each party tended to support solutions trying to understand and mitigate the systemic drivers for those high costs.

Fifth, the most productive conversations about solving health care costs were most likely to occur in states with pockets of expertise. A pocket of expertise is a small number of people who have spent considerable time thinking about health care costs and have developed channels of information sharing with each other. These policymakers almost universally thought about solving health care costs in systemic terms and were able to move the conversation in their states in this direction. Specific examples from these states illuminate our sixth finding, which is that people in these pockets of expertise are framing proposals about health care costs to appeal to legislators focused on both individual and systemic drivers of cost by emphasizing both affordability and transparency.

Our survey did not uncover deeply entrenched partisan splits on the issue of health care costs, and there was a commitment on all sides to tackle the issue. What this tells us is that the answer to rising health care costs may well lie in initiating state-level conversations among moderates and reframing the way we talk about health care costs, rather than in overturning deeply held ideological beliefs. In sum, there is a way to move forward.

Introduction

Health reform has been a politically charged issue for more than a decade. In the 2020 election cycle, candidates for offices at all levels of government talked about the future of health care. The outbreak of the 2019 novel coronavirus disease (COVID-19) has only underscored the urgency of fixing gaps in the US health care system. Although conversations about health reform can very quickly turn partisan and polarized, that does not have to be the case. Our research over the past three years suggests that there is more opportunity for bipartisan agreement than many realize, particularly at the state level and particularly on the issue of health care costs.

In early 2017 we sent a survey to state legislators serving on health, budget, or appropriations committees, asking them to rank their health policy priorities. We were not surprised that Democrats prioritized expanding access to care and reducing disparities, while Republicans said reducing the role of government was their top priority. It was noteworthy, however, that respondents from both parties ranked health care costs among their top priorities.¹

Consensus among state legislators on the importance of health care costs reflects public opinion more broadly. A February 2020 survey by the Pew Research Center indicates that two-thirds of Americans rank health care costs as a top priority, second only to terrorism. Democratic voters were particularly likely to prioritize health care costs (80%), but this was true for more than half of Republican voters (52%) as well.² Little is known about how this overlapping group of people think about the root causes and policy solutions for rising health care costs.

Governors also prioritize health care costs. Most mentioned rising costs in their 2020 state of the state speeches; no other health policy issue was mentioned more often. This was true of governors that were new and returning, as well as governors in both political parties and in all parts of the country.³

In the fall of 2017, we went to Colorado and Kansas to interview policymakers and key stakeholders about our survey from earlier that year. We hoped to emerge with a clearer picture of the bipartisan path to state-level solutions for rising health care costs. Instead, we found that consensus that costs are a priority does not necessarily mean that there is agreement on what solutions should be adopted. People meant very different things when they said that health care costs are a priority. Some referred to costs borne by individuals, such as premiums and deductibles, whereas others were focused on costs to providers, insurers, hospitals, or the government. In other words, it was hard to talk about specific policy solutions because there was a lack of consensus on what problems needed to be solved. Developing this shared understanding is a critical next step toward developing bipartisan solutions.⁴

Figure 1. Overall Health Policy Importance Map for Mostly Democratic Group of Legislators (80% Democratic, 20% Republican)

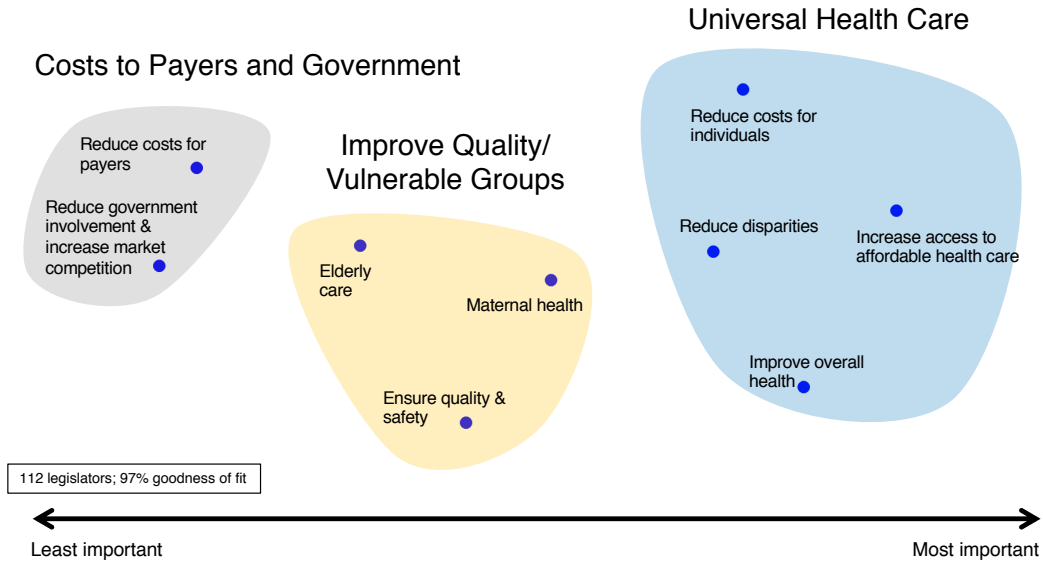


Figure 2. Overall Health Policy Importance Map for Mostly Republican Group of Legislators (20% Democratic, 80% Republican)

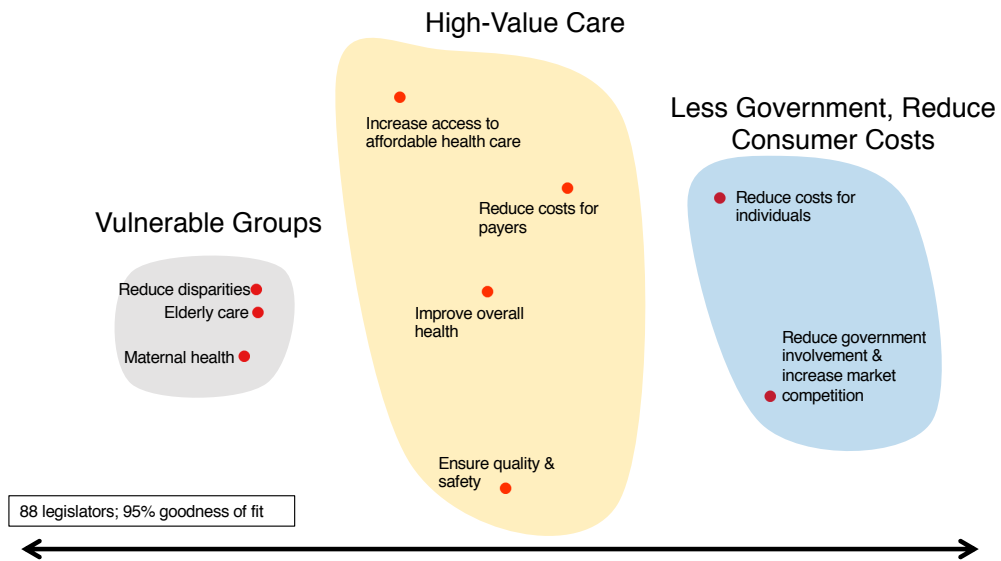
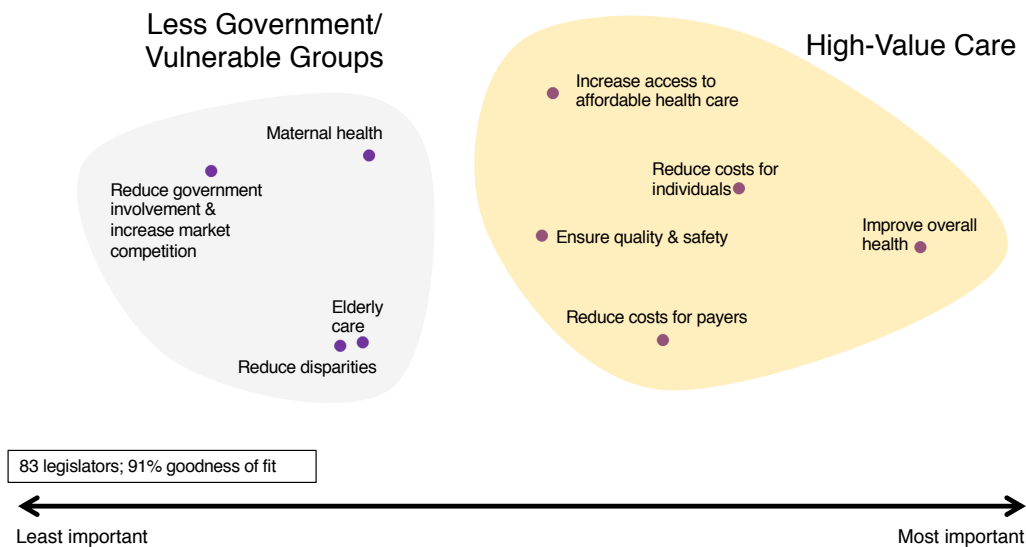


Figure 3. Overall Health Policy Importance Map for Moderate Group of Legislators (50% Democratic, 50% Republican)



In 2019 we repeated this process of surveying and interviewing state leaders. First, we invited every state legislator serving on a health, budget, or appropriations committee to complete an online survey. As in 2017, we asked them to rank their priorities for health policy. This time we added a question focused on health care costs, asking state legislators to rank which specific types of health care costs should be prioritized. The list of possible health care costs was developed in consultation with legislators from the Milbank Memorial Fund’s Reforming States Group of state health policy leaders (see the Appendix for more details on our methodology).

We visited four states following the survey to get a broader and more representative sense of the conversations happening across the country. We selected states from different geographic regions and with each combination of partisan composition between the governor and legislature. Between early October and early December 2019 we went to Colorado (West: Democratic governor, Democratic legislature), Michigan (Midwest: Democratic governor, Republican legislature), South Carolina (South: Republican governor, Republican legislature), and Vermont (Northeast: Republican governor, Democratic legislature).

Note that these conversations took place just before the COVID-19 outbreak. It is hard to know exactly how perspectives have changed as a result. But it’s likely that the resulting health and economic crises have intensified pressure on state leaders to come together and tackle health care costs.

This report highlights six principal findings about how policymakers at the state level view health care costs. Along the way we discuss some of the specific policies our case-study

states are adopting, but our goal is not to provide a comprehensive overview of these approaches. Instead, our aim is to better understand what policymakers mean when they say that health care costs are a priority and to lay the foundation for a more productive conversation.

Finding 1: There Are Three Parties, Not Two

Before exploring the health care costs issue, we surveyed legislators on their health policy priorities in general. Just as in 2017, our latest survey results show that the two major political parties have strikingly different health policy priorities. Once again, Republicans were more likely to rank reducing the role of government as most important, whereas Democrats said this was their lowest priority.

To avoid applying a strictly binary lens determined by party affiliation, for the 2019 survey we used statistical techniques to find groups of legislators who ranked health policy goals similarly *without* separating by party. The goal was to look for the unifying issues and then see how they mapped onto partisanship. What we found was striking and suggests more overlap between the parties than one might assume.

We found that there are effectively three similarly sized, distinct groups of legislators in terms of priorities on health policy. One group is predominantly Democratic, one is predominantly Republican, and the third (which we've termed "the moderates") is evenly split between the two parties. About 60% of Democrats fall into the mainly Democratic group, 10% in the mainly Republican group, and the remaining 30% in the moderate group. The picture is almost exactly inverse for Republicans.

Figures 1–3 illustrate how state legislators responded to the question about their overall priorities for health policy. Note that while the horizontal axis in these figures represents importance across all groups, the vertical axis can represent different measures for each group and vertical separation is harder to interpret. We have thus left the vertical axis unlabeled (please see the Appendix for more discussion on this point).

These importance maps are generated directly from people's survey responses and highlight some key differences between the groups that exemplify the partisan splits that have made compromise so difficult. For example, one of the major contrasts between the predominantly Republican and predominantly Democratic groups is the difference in emphasis placed on increasing access and reducing disparities. However, both groups once again ranked "costs for individuals" among their top priorities.

The predominantly Republican and predominantly Democratic groups differed dramatically in how they view the role of government. Republicans said that reducing the role of government is their top health policy priority, whereas Democrats said it is the least important. At first glance, this disagreement might seem to suggest that bipartisan conversations are unlikely to be fruitful because they will hit this fundamental impasse. However, the moderate

group seems to serve as a bridge between the two parties, giving hope that compromise is indeed possible.

One of the most striking results is that responses from moderates match the predominantly Democratic group in saying that improving overall health is a top priority and reducing the role of government is their lowest priority. This important insight suggests that ideological differences over the role of government might not be as big a barrier in some states as many assume. The moderate group also agrees with both parties that reducing costs for individuals is a top priority, but it is more like the predominantly Republican group in placing higher priority on the costs to payers.

Our four case-study states provide insights on the conditions most conducive to productive conversation and cooperation across these three groups. For example, one important condition is which party is dominant. Democrats have such a strong hold in Colorado and Vermont that party politics does not always resemble divisions at the national level. Policy solutions here are described as most likely when the predominantly Democratic group works together with moderate Democrats and moderate Republicans.

Geography also plays a major role in Colorado and Vermont, with legislators agreeing or disagreeing within and across parties based on whether their district is urban, suburban, or rural. As a Republican legislator from a remote area said, “Maybe because I represent rural Colorado and have different interests, I don’t feel the partisanship and ideological walls as strongly.” This person was so concerned about rural hospital closures in their area that they were willing to accept a stronger role for government, including Medicaid expansion. A Democrat in the Colorado legislature made the same observation: “The experience I’ve had here in this legislature is that there is a significant number of rural Republicans who are willing to depart from what was kind of a traditional Republican position to embrace changes that would directly help their constituents because they are feeling the pain of costs.”

The need for bipartisan compromise is particularly evident in Michigan, where Governor Gretchen Whitmer is a Democrat and Republicans have controlled both chambers of the legislature for a decade. Bipartisan compromise is thus most likely when moderates from both parties are able to work together and appeal to other, less moderate members of their respective parties. The results of our survey suggest that for this to happen, moderate Democrats may need to be willing to downplay the importance of reducing disparities, which our survey shows is not a top concern for Republicans. Geography is also a major factor in Michigan politics, though interviewees said that, unlike in Colorado, legislators in the more rural communities are likely to be the most conservative, while the Republicans from suburban districts are more likely to be moderate.

Finally, the three-party breakdown in the results of our survey helps explain why bipartisan compromise has been so difficult in South Carolina. The key tension here is largely between

moderate and more conservative Republicans. Solutions-oriented conversations are not likely to happen in South Carolina unless they avoid triggering differences of opinion on the role of government and de-emphasize reducing disparities while emphasizing reducing costs to payers, two points of consensus for moderate and conservative Republicans. Our survey results suggest that focusing on “improving overall health” would be a potential way to appeal to moderates and Democrats, without alienating people in the predominantly Republican group of the reddest states.

Finding 2: Health Care Costs Are Not Inherently Partisan

As in 2017, survey respondents on all sides said that health care costs were a top priority, particularly costs for individuals and families. This is not to say that everyone had the same understanding of what “health care costs” means or which costs are the most important to address. In fact, responses to our recent survey revealed a wide range of health-care-cost priorities, with the split not falling neatly along partisan lines.

The first finding that there are actually three partisan groups (predominantly Democratic, predominantly Republican, and moderates from both parties) provided a useful lens through which to view the results of our costs questions, where again we see that the moderate group shares priorities across both the Republican and Democratic groups (Table 1 and Figure 4). One of the clearest messages that emerged was that there was not an obvious conceptual linkage explaining how the different groups see costs.

It does *not* seem possible from these results to develop a taxonomy of health care costs that serves as an organizing principle for how different types of legislators think about costs. This finding of a nonfinding is at first glance frustrating but might actually be *good* news. Health care costs are not an inherently partisan issue and people’s understanding of what they mean does not seem hard-wired. This means that there is more of an opportunity for legislative leaders, stakeholder groups, and academics to shape policymakers’ understanding of health care costs and work toward solutions than many realize.

Whether and how it’s possible to develop solutions depends on state-specific dynamics and the leadership abilities of individuals. While traveling the country interviewing state legislators, we discovered that legislators in many places are already coming together across party lines to address health care costs. The most promising conversations are happening between policymakers who most closely resemble the moderate respondents in our survey.

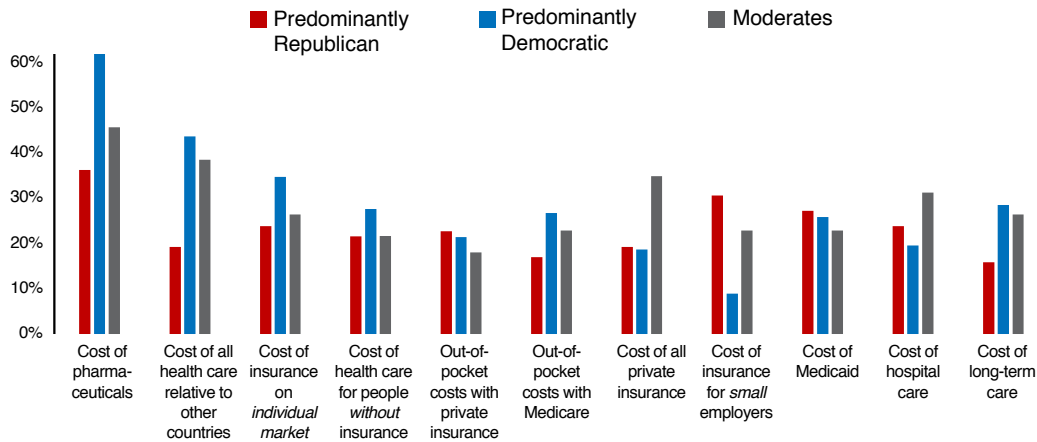
Table 1. Health-Care-Cost Priorities

Group priorities for tackling health care costs within each of the three partisan groups. Group priorities were calculated from individual responses, where each legislator was asked to rank their seven most important costs from a list of 17 possible categories. The top five priorities in each group are shown in bold font.

Ranking	Predominantly Republican Group	Predominantly Democratic Group	Moderates Group
1	Cost of pharmaceuticals	Cost of pharmaceuticals	Cost of pharmaceuticals
2	Cost of Medicaid	Overall costs compared to other countries	Overall costs compared to other countries
3	Cost of insurance on individual market	Cost of insurance on individual market	Cost of all private insurance
4	Insurance costs for small employers	Medicare out-of-pocket costs	Cost of long-term/residential care
5	Private insurance out-of-pocket costs	Cost of health care for the uninsured	Cost of hospital or specialist care
6	Cost of hospital or specialist care	Cost of long-term/residential care	Cost of Medicare
7	Cost of all private insurance	Cost of Medicaid	Cost of insurance on individual market
8	Cost of health care for the uninsured	Cost of behavioral/mental health care	Medicare out-of-pocket costs
9	Cost of long-term/residential care	Private insurance out-of-pocket costs	Private insurance out-of-pocket costs
10	Cost of primary care services	Cost of hospital or specialist care	Insurance costs for small employers
11	Overall costs compared to other countries	Cost of Medicare	Cost of health care for the uninsured
12	Cost of behavioral/mental health care	Cost of all private insurance	Treating people with unhealthy behaviors
13	Cost of Medicare	Cost of primary care services	Cost of Medicaid
14	Medicare out-of-pocket costs	Insurance costs for small employers	Cost of behavioral/mental health care
15	Insurance costs for large employers	Treating people with unhealthy behaviors	Cost of primary care services
16	Treating people with unhealthy behaviors	Cost of dental care	Cost of dental care
17	Cost of dental care	Insurance costs for large employers	Insurance costs for large employers

Figure 4. Cost Priorities for the Three Groups of Legislators

Proportion of legislators ranking cost dimension in top 5



This graph shows the proportion of legislators within each of the three partisan groups who ranked each health-care-cost priority in their top five. Only cost priorities that were ranked in the top five within any of the three groups in Table 1 are shown. The moderates are similar to the Democrats in how they prioritize pharmaceuticals, costs compared to other countries, and long-term care, but are more like the Republicans in how they prioritize costs for small employers, those without health insurance, and the cost of health insurance on the individual market.

For example, the vast majority of health reform bills enacted by the Colorado legislature in 2019 had wide bipartisan support. As one Democrat put it, “Health care costs is 100%, by far, the most important issue for me as a legislator, because it’s the most important issue that I hear about from my constituents. . . . It doesn’t matter whether you’re a Republican or Democrat, you’re going to be affected by high cost of health care if that exists in your area.”

A Republican in a rural part of the state agreed and explained why they were willing to work with Democrats. “It’s too easy and a waste of time to say we’re going to reduce the role of government,” he said. “What does that mean? . . . So, I think what we have to do is tackle the problem as it exists.”

We heard the same thing in Vermont. For example, a Republican pointed to the bipartisan implementation of the Medicaid waiver agreement, which is the foundation for the state’s new accountable care organization that many hope will allow the state to do more to control health care costs. They said:

This is really what’s so impressive about health care. You’ve got basically an agreement that was signed by the Obama administration and the Shumlin

administration. And now the Trump administration and the Scott administration are continuing to work full speed ahead on it, because it doesn't matter if you are an advocate for single-payer or you believe government shouldn't be involved in that at all. You still want to contain costs. I mean, it's that simple.

As this person notes, it is striking that a Republican governor is working with a Republican presidential administration to implement the agreement developed between a Democratic governor and a Democratic presidential administration.

Michigan is an important test of the limits of bipartisan cooperation on health care costs. At the time of our visit, the governor and legislature were in the midst of an intense fight over the budget. Democratic governor Gretchen Whitmer had recently approved the budget passed by the Republican-controlled legislature, but with 147 line-item vetoes blocking nearly \$1 billion in spending.⁵ This impasse was ultimately resolved, but it left bitter feelings on both sides. Some health reform issues—such as Medicaid work requirements—are treated as a highly partisan battleground in the national fight over the Affordable Care Act (ACA).

Health care costs have generally transcended the broader partisan rancor and even the intense fights over the ACA. As the leader of a nonpartisan policy think tank put it, “There is terrible partisanship in Michigan, but not on this issue.” This person explained that Michigan legislators “have simultaneously been walking and chewing gum at the same time. . . . Tons of stuff is passing, even as they're throwing bombs at each other in the media. . . . And so, [health care costs] has kind of transcended.”

Much of the conversation about health care costs in Michigan has focused on protecting consumers from surprise medical billing. The problem arises as people do not realize they are receiving care from a provider who is outside their insurance plan's network until they receive a bill that is dramatically higher than expected. A package of bills passed the Michigan House on a 101-5 vote and is pending in the state Senate after bipartisan approval from a key Senate committee. The plan calls for hospitals to give at least 24 hours' notice for any services that will be provided to someone by a provider out of their network. Patients receiving care in an emergency situation will be protected from surprise fees. The reform also specifies that out-of-network providers will be prohibited from charging more than 125% of Medicare rates.⁶ A few people we spoke with said they were surprised that the bipartisan team of legislators took such a strong rate-setting approach to addressing surprise medical billing.

A Democratic member of the Michigan House Health Policy Committee credited the Republican chairman for the progress on legislation to address health care costs. “It's the best committee, I think, in the House. The chair is a super-awesome Republican member. He believes in bipartisan work and he believes in consensus. . . . So rarely is there a bill brought to Health Policy that he does not think that the Dems support also.”

By contrast, the fight over the ACA has spilled over in South Carolina to the extent that all health policy issues seem to be toxic, including costs. A nonpartisan stakeholder explained that other than the cost to government of the state Medicaid budget, health care costs in South Carolina are ignored. They added, “It’s like health care doesn’t even exist. So it’s not like we fought to a draw. It’s like we just agreed not to talk about health care anymore.” Party politics here leave little room for a coalition of moderate Republicans and moderate Democrats to work together.

Finding 3: All Groups Prioritized the Costs of Pharmaceuticals

If health care costs are not inherently partisan in most states, the question then becomes, How do we move toward solutions? Despite the relative lack of consistency in how policymakers on all sides think of health care costs, there is one promising shared interest: lowering pharmaceutical costs (Figure 4).

Perhaps this is not surprising given that pharmaceutical costs have been a high-profile national issue for many years and are an important driver of costs for payers, providers, and consumers alike. Both the Republican and Democratic nominees for president in 2016 talked extensively about drug costs during the election, even agreeing at times about what should be done. Yet little has happened at the federal level during the Trump administration, increasing pressure on states to act. More than one-fifth of governors mentioned the cost of pharmaceuticals in their 2020 state of the state speech.⁷

The stakeholders we interviewed said drug costs are one of the issues they hear about most from their constituents. Legislators—particularly Democrats and moderate Republicans—tend to agree on the importance of pharmaceutical costs because they see it as a market failure that government needs to address. For example, when discussing a specific drug, a Democrat in Colorado said, “There is no justification for why it costs as much. No one is really saying that the R&D or the acquisition of the other company or whatever was what drove that cost. They’re just pricing it that way because that’s market practice.”

But there was still resistance among more conservative Republicans in South Carolina to granting a larger role for government in addressing drug costs. Some felt that pharmaceutical companies were an easy target for blame but that ultimately legislators would not make the difficult decision to increase regulation of this powerful industry. This also seemed to be the case in Michigan, where legislators told us that there is bipartisan support among rank-and-file legislators for increased transparency in pharmaceutical pricing, but interest-group influence on leadership has prevented such bills from advancing.

Finding 4: Legislators Are Divided Over Whether Solutions Should Focus on Individuals or Systems

The tension over how to address pharmaceutical costs epitomizes another major theme that emerged in our survey and interviews: Should policymakers focus on mitigating how health care costs affect individuals or on changing the drivers of increased costs?

Legislators whose perspectives were most like those in the predominantly Republican group on our survey seemed most focused on solutions that address costs as an individual issue without making the jump to changing the underlying systemic drivers. They were drawn to ideas in which the government played a minimal role and where they saw market forces at work. For example, a Republican legislator in Colorado admiringly described a company that is flying American patients and doctors to Mexico to perform nonemergency procedures such as knee and hip replacements more cheaply.

By contrast, Democrats and moderate Republicans tended to be confused by the question of whether they see addressing health care costs as an individual or systemic issue. In their view, changing the underlying drivers is the way to ultimately make health care more affordable for individuals. As a leader in Colorado put it, “Saving people money is one thing, but it has to be in this overall conversation about what are the most broken parts of our system.”

Policymakers in these groups tended to focus on the role of hospitals and/or insurance companies in pushing up health care costs. For example, a Republican in Michigan explained, “Everybody, when they look at the cost of health care, looks at the cost of insurance. . . . But that, I think, is going past the actual cost, which is the cost of the health care. And we do great, great health care. But I don’t think we have . . . a very efficient delivery system of health care.”

Another leader in Michigan said that insurers should use their leverage to drive down costs for people. “At the end of the day, I don’t even like that this is true, but insurance companies have way more power to change that than the average consumer paying cash out of their pocket. . . . I wish that they used their market power better. I’m sure doctors and hospitals would say, ‘I wish they used it less.’”

A Republican in Colorado made a similar point. “Hospitals have taken all the heat, and I don’t think that’s totally fair. I blame the insurance companies. It’s not their fault because of their model. What motivation do they have to really negotiate hard with a hospital over rates or their other networks? I mean, as long as their profits are based on volume. I don’t hold them harmless, and they argue with me over that. They want me to go after the hospital.”

Finding 5: How Pockets of Expertise Are Bridging Divides

Taken together, the results of our survey and our interviews suggest that legislators have very different ways of thinking about the drivers of health care costs, but that these differences are not strongly partisan. Consensus is possible, particularly among the predominantly Democratic legislators and the moderates of each party who seem more likely to bring both a systemic and individual lens to thinking about how to address health care costs. However, a limitation to our analysis is that the legislators whom we spoke with all served on committees dealing with health and likely responded to our request for an interview because they are particularly interested in health policy. Although they saw the individual and systemic cost issues as inseparable, they did not think the average legislator in their state shared this understanding.

A Democrat in Vermont explained, “Most legislators don’t spend the time to understand why things cost what they cost, or what a state can do about it, so it’s harder for them to talk about that publicly. It’s easier to blame the government or blame the insurance company or whoever else are perceived as stopping us from having a universal system. . . . I don’t think there are many people looking at reducing system costs.” A stakeholder in Michigan echoed this sentiment, saying, “I think it’s because health care is wickedly complex. . . . Education policy is complex and it’s long term—it takes long-term thinking. Tax policy is complex; fiscal policy. But I think health policy, among this group, is the most difficult for people to really understand. The economy does not work in health care as it does in anything else.”

Even so, political science research shows that it is not necessary for all legislators to develop a full understanding of a topic for evidence-based policy to be developed. It is often enough to have “pockets of expertise,” in which a small core group of policymakers become the trusted sources of information and lead policy development.⁸ Many people we spoke with in Vermont said that the failed attempt at creating a single-payer system helped to form this pocket of expertise by crystallizing an understanding among a core group of legislators and executive branch leaders about the underlying reasons for high health care costs. Some states have tried to catalyze and facilitate this expertise. Two examples are Massachusetts, which created a state Health Policy Commission, and Rhode Island, which created the role of Health Insurance Commissioner to improve the quality and efficiency of health care services.

Our analysis suggests that these legislative pockets of expertise can make the conversation about health care costs more accessible to policymakers across the political spectrum by explicitly making the connection between individual and systemic costs. Proposals to address the systemic drivers of health should therefore be framed in terms of how they help people with their premiums, deductibles, and other out-of-pocket costs.

Finding 6: Ways Forward Can Include a Focus on Affordability and Transparency

These core groups of health policy makers in our case-study states are leading the way by showing how to make the connection between individual and systemic costs. For example, one of the first actions that Colorado Governor Polis took upon taking office was creating the Office of Saving People Money on Health Care.⁹ This new department provides a central point of communication and coordination across the many arms of state government that influence health care costs, including the Colorado House and Senate, the Division of Insurance within the Department of Regulatory Agencies, the state's Medicaid program (known as Health First Colorado), and the Colorado Department of Health Care Policy and Financing. But just as important, the department's name epitomizes a deliberate and disciplined effort to consistently frame reforms in terms of affordability, or how the changes will help individual people. As a leader in one of the state agencies said, "[This is] a simple name, so people would understand what we are doing." This framing has been applied to a variety of novel policy ideas, such as the development of a public health insurance option and rate-setting for insurers.

The idea of increased transparency about health care prices is another important conceptual bridge. Legislators from all three groups supported transparency, including the most liberal in blue states and the most conservative in red states. For some, transparency is a way to increase the power of consumers to make informed decisions. However, there is little evidence that price transparency tools, such as online databases where people can compare prices, change how so-called consumers make decisions about when and where to access health care.

Some policymakers are interested in using transparency to help government regulators make better-informed decisions. For example, health care price transparency is required as part of bills focused on pharmaceutical pricing in Michigan, premium rate-setting in Colorado, and a process in Vermont in which hospitals are required to submit their budgets to a state agency for annual approval. A leader in Vermont described their state's hospital budget review as "a sunlight review, meaning they have to come in and publicly say the basis for how much they're going to be charging people. That alone probably has more effect on the way the hospital makes decisions about what it's going to ask for, just by virtue of publicity and openness that they're required to show."

Similarly, leaders in Colorado say that increased transparency has revealed dramatic variation in health care prices across the state. In their view, one reason the state is spending so much on health care is that some hospitals are charging more than is needed. They are challenging hospitals about these differences and raising questions about what constitutes a reasonable profit margin for hospitals. The idea is that a more "appropriate" profit margin would lower costs for insurers, which would pass these savings on to consumers.

One reason health care price transparency has received bipartisan support—at least from legislators in the predominantly Democratic and moderate groups—is that it is based in two core values that appeal to people on both sides: transparency and value. Moderate Republicans say that it is impossible to entirely eliminate government’s role in health care, so the state should proactively ensure it gets value for what it spends. Moderate Republicans also see transparency as a way to strengthen markets. For example, a Republican legislator in Colorado described why they supported the Polis administration’s examination of hospital profit margins: “My local hospital, it’s like a 30-bed hospital, and the CEO makes a million and a half dollars a year. This transparency lets us get at their books a little bit. Now, look, as a conservative, I don’t think I have the right to dig into the books of a private business. But some of these people, they claim to be nonprofits, and they’re also doing a large portion of Medicaid. So, I do have a responsibility to know what they’re doing in those categories. So, how do I use that responsibility, that authority when I’ve got these private enterprises pushing back saying, wait a minute, aren’t you a free market? It’s not a free market.”

Conclusion

Three years ago, our work revealed that while there was general bipartisan consensus on the importance of reducing health care costs, this consensus broke down when discussion moved to the specifics of which health care costs to reduce and how to do it. We undertook this new survey and series of interviews last year to try to understand this complex issue further by asking: Which health care costs do legislators prioritize? How do legislators think about costs? Do legislators from different parties think differently about health care policy more generally or health care costs more specifically?

The combined results from our 2019 survey of 283 legislators and interviews across four diverse states further reveal the inherent complexity of health care costs, but also offers some key insights that we hope can support future legislative efforts to tackle health care costs.

Our overall message is one of hope: we did not find deeply entrenched partisan splits on the issue of health care costs, and there was a commitment on all sides to tackle the issue. This finding is supported by other independent surveys.¹⁰ The answer to rising health care costs may well lie in initiating state-level conversations among moderates and reframing the way we talk about health care costs rather than in overturning deeply held ideological beliefs. Everyone does not have to become an expert on health care financing for change to become possible, as pockets of expertise can drive a solutions-oriented conversation that addresses the systemic root causes while skillfully framing policy ideas in terms of how they will benefit individuals. Several examples of successful action on health care costs from across the states we visited—and others that we did not, such as California,¹¹ New Jersey,¹² and Connecticut¹³—provide a rich source of ideas for where to start.

Notes

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Appendix

Survey Design

In 2017 we ran a survey of legislators asking them to rank their most important goals of national health policy from a list of 13 possible priorities.¹ That survey was sent out in the mail twice over two months to 2,973 legislators identified as members of health or budget committees in all state Senates and Assemblies. We received 377 responses (13%), almost equally split between Republicans and Democrats. This is a typical response rate for surveys of busy, high-profile groups such as legislators.

For the 2019 survey, we adapted the original questionnaire to ask legislators to rank only nine out of the thirteen original options, discarding the least popular 2017 options. The nine options were:

- Reduce government involvement
- Ensure quality & safety of health care
- Improve care for elderly
- Reduce costs for payers
- Reduce costs for individuals & families
- Improve overall health
- Improve maternal health
- Reduce disparities
- Increase access to affordable care

We also added a question asking legislators to rank their most important priorities for which health care costs to tackle from a list of 17 possible costs. The list of possible costs was developed together with the Milbank Memorial Fund and a group of seven sitting state legislators with an interest in health care policy and one policy advisor from a governor's office. Input from these policymakers refined both the content and language of the options. We aimed for a comprehensive list of aspects of health care costs and neutral language. The final set of options survey respondents were asked to prioritize were as follows:

- Cost of health insurance for small employers (under 50 employees)
- Cost of health insurance for large employers (over 50 employees)
- Cost of health insurance in the individual market
- Cost all private insurance
- Cost of Medicaid
- Cost of Medicare
- Out of pocket costs (co-pays, deductibles, costs for care that is not covered) for those with private insurance
- Out of pocket costs (co-pays, deductibles, costs for care that is not covered) for those with Medicare

- Cost of health care for people with no insurance coverage
- Cost of hospital, facility or specialist care
- Cost of long-term care / residential care
- Cost of primary care services (including physicians, nurses, physiotherapists)
- Cost of dental care
- Cost of pharmaceuticals
- Cost of behavioral health care (e.g., mental health or substance abuse)
- Cost of treating people with unhealthy behaviors (e.g., tobacco use)
- Cost of all health care in the US relative to other countries

In addition, we asked basic demographic information such as state, legislative chamber, and length of service as a legislator.

Survey Administration

To reduce costs and to facilitate rapid administration and reduced data entry burden, we delivered the survey online. Legislators were invited to participate through a personalized email, which included a study information sheet explaining the purpose of the survey and how the data would be used. Online surveys have lower response rates than paper surveys, but we tried hard to increase our response rates by enlisting the help of members of the Reforming States Group in each state to endorse the survey and encourage their colleagues to respond.

We invited 3,425 legislators serving on health or budgetary committees across the United States to complete the survey and received 306 responses (8.9%). Their regional and party breakdown is given in Table A1.

Table A1. Regional and Party Breakdown of Survey Participants

Proportion Responded (Number responded / Number invited)				
Region	Republican	Democrat	Independent	Total
Midwest	13% (71/555)	9% (28/328)	0% (0/1)	11% (99/884)
Northeast	6% (17/273)	13% (68/532)	33% (3/9)	11% (88/814)
South	3% (23/689)	4% (17/413)	50% (2/4)	4% (42/1106)
West	10% (27/279)	14% (47/340)	100% (2/2)	12% (76/621)
Total	8% (139/1796)	10% (160/1613)	44% (7/16)	9% (306/3425)

To reduce burden on legislators, we asked them to only rank their top seven options for each question. Even so, not everyone who responded answered all the questions, and there was a significant drop-out rate between answering the general goals of health policy and the cost priority question, likely because the cost question had so many more options. Survey section completion is shown in Table A2.

Table A2. Survey Completion Rates

Survey Completion	Republican	Democrat	Independent	Total
Opened survey	139	160	7	306
Answered goals question	127 (91%)	149 (93%)	7 (100%)	283 (92%)
Answered costs question	104 (77%)	123 (77%)	7 (100%)	234 (76%)

Survey Analysis

We performed a basic descriptive analysis of the ranks assigned to each health policy goal and each aspect of costs. There were no significant differences by region, chamber, committee type, or length of service. There were significant differences between parties on health policy goals but very few significant differences on costs. The only cost differences were that Democrats were significantly more likely to prioritize costs for the uninsured and all costs compared to other countries than Republicans.

For each of the ranking questions we generated group rankings of goals using a hierarchy of pairwise preferences.^{2,3} The highest rank option is that which is preferred by a majority of legislators to every other option; the next highest option is that which loses in a pairwise contest to the top option but is preferred to every other option by a majority of legislators; and so on. This provides a robust ordering of preferences.

Health Policy Goals

The face-to-face interviews we conducted in two states following the 2017 survey suggested that there were moderates within each party whose goals of health policy were more similar than the extremes of either party.^{4,5} To see if this was supported in the survey data, we ran a statistical method (k-means clustering) on the policy goal rankings, which grouped legislators into distinct groups that tended to rank goals similarly. This method identified three distinct groups of legislators, one predominantly Republican (88 legislators), one predominantly Democratic (112 legislators), and the third an even mix between the two (83 legislators).

We generated overall group rankings for health policy goals for each of the three identified groups. We also created importance maps of each group's health policy rankings using multidimensional scaling methods.⁶ In any such mapping, the axes represent the dimensions that most capture the separation between points. What these dimensions represent are for the interpretation of the reader, but since the position of the points are based on rankings of importance, the x-axis (most important axis) must represent importance. Therefore, we have labeled it as importance in the figures in the main report. However, the y-axis is open to interpretation, and although the x-axis has to be the same for all groups, the y-axis does not have to be.

Clusters of goals that tended to be ranked similarly within each group were identified using hierarchical cluster analysis on the full-dimensional data and highlighted on the importance maps.⁷

Ranking of Health Costs

We generated overall group rankings of health policy goals for each of the three identified partisan groups (Table 1 in the main report). There were no significant differences in cost rankings between the three groups except that the predominantly Democratic group was more likely to rank pharmaceutical costs higher than the other two groups and both the predominantly Democratic group and the moderate group were more likely to rank all costs compared to other countries higher than the predominantly Republican group.

We tried grouping legislators based only on similarity of how they ranked costs using the same methods as above (k-means clustering). We did find four distinct groups of legislators who had significantly different cost rankings, but there was no obvious organizing principle by which to understand the different groups. The biggest finding from the four groups was that all of them contained a mix of both Republican and Democratic legislators, consolidating our main finding that how legislators prioritize health care costs is not particularly partisan.

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The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

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