Affordability, Decoded: Learnings from a Health Economics Researcher

imagine360

Affordability, Decoded: Learnings from a Health Economics Researcher

When employers talk about healthcare costs, the conversation almost always starts from the same assumptions: Prices are high because government programs underpay. Hospitals charge more to offset uncompensated care. Higher prices reflect better-quality care. Those explanations have shaped healthcare decision-making for years — and they're the reasons many employers keep cycling through traditional health plan carriers, plan designs and so-called cost-containment strategies and programs in order to contain costs. Despite those efforts, however, costs continue to rise; and affordability — for both employers and their employees — slips further out of reach.

Roslyn Murray says that may be because the assumptions employers make about what's driving the rises are not informed by actual data.

As an assistant professor at Brown University who studies commercial healthcare spending and the policies designed to reduce it, Murray has spent years examining why employer costs continue to grow so relentlessly — and the things traditional cost-containment strategies miss. Research shows that prices are driven less by utilization rates and more by hospital market consolidations and providers' pricing power[1]. And until leaders acknowledge that reality, she argues, even the most-well-intentioned strategies will fail to make a meaningful dent in rising healthcare spending.

In this conversation, Murray provides a research-based argument for some of the most-persistent myths about the sources of rising healthcare spending and explores what it will take for employers to reset their approaches. From why familiar solutions fall short to how reference-based pricing (RBP) is reshaping the conversation, she offers a candid view of what leaders need to unlearn — and where they should focus next — to build affordability strategies that actually work.

Why a data-informed strategy matters in solving the affordability crisis

Recent research into commercial healthcare spending has fundamentally reshaped our understanding of why costs continue to rise — and why so many cost-containment strategies fall short. Across multiple industry studies, evidence consistently shows that the biggest drivers of commercial healthcare spending growth are not overutilization, excessive patient demand or shortfalls in public payment rates. Instead, hospital market consolidation and the pricing power that comes with it account for much of the cost escalation employers face today.

MEET ROSLYN MURRAY

Roslyn Murray is an assistant professor of health services, policy and practice at Brown University's School of Public Health, where her research focuses on commercial healthcare spending, hospital pricing and state-level policy interventions aimed at improving affordability. She is also affiliated with the Center for Advancing Health Policy through Research (CAHPR), where she works to translate complex economic data into actionable insights for policymakers and employers.

Murray's research is grounded in data from which she models the impact of rising healthcare spending and provides leaders with a clearer understanding of what is driving spending growth.

Q We've seen employers lean on high-deductible plans, wellness programs and even value-based payment models to rein in rising healthcare spending. Why haven't these approaches resolved the affordability crisis?

A It's not surprising that traditional cost-saving approaches haven't worked — mainly because organizations aren't addressing what's likely the biggest driver of commercial healthcare spending growth. A lot of the cost-saving strategies employers have leaned on focus on utilization or on changing patient behavior, but the research shows that utilization hasn't been the main driver of cost increases for the employer-sponsored insurance market. Prices have. So, if we're targeting the wrong part of the spending equation, it shouldn't be a surprise that these traditional approaches are not moving the needle.

For example, in our review of commercial value-based payment models[2], the results are relatively underwhelming. There is little to no evidence of savings for employers, largely because those models don't really get at the core issue of how much hospitals are paid[3]. And even when there is some evidence of reductions in spending through lower utilization, these models still aren't addressing the core issue: prices. A payment model can change how care gets delivered, but if hospitals and physician groups have the leverage to set high commercial prices, those prices remain high. That's why, even with all the investment and enthusiasm around value-based care, we haven't seen a major improvement in affordability for employers.

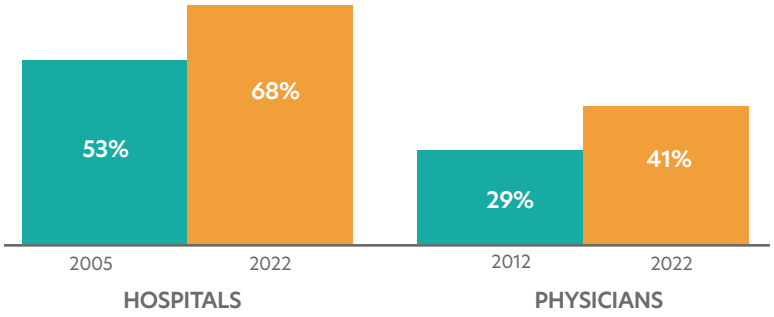
By 2016, Metropolitan Statistical Areas were highly concentrated[4]:

90% for hospitals

65% for specialist physicians

39% for primary care physicians

AN INCREASING SHARE OF HOSPITALS ARE AFFILIATED WITH HEALTH SYSTEMS AND AN INCREASING SHARE OF PHYSICIANS ARE AFFILIATED WITH HOSPITALS OR HEALTH SYSTEMS[4]



Q If utilization isn't the main driver of costs, why do so many employer strategies and programs still target how much care people use rather than the prices being charged?

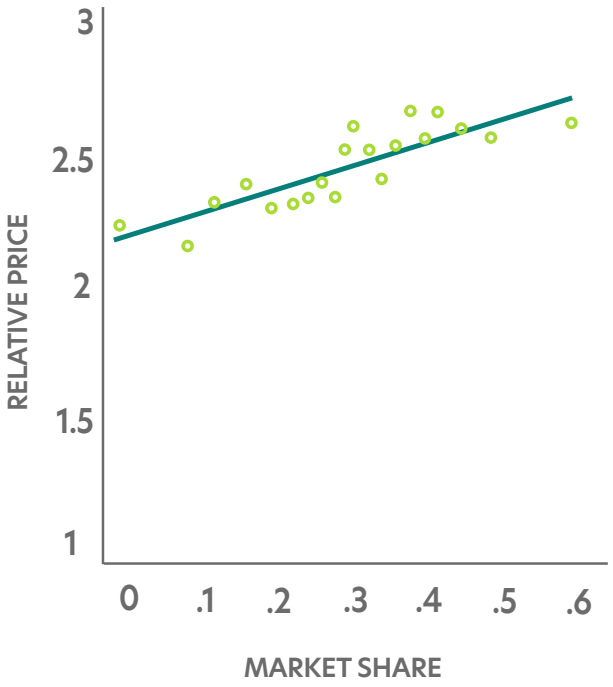
A Part of the dynamic is that utilization feels more actionable. It's easier to design programs that attempt to change patient behavior or reduce unnecessary care than it is to take on hospital prices. And there's also a deeply held assumption that if we just make care more efficient, costs will come down. This may be true for public payers, like Medicare and Medicaid, which set prices administratively. But it's not necessarily true in the commercial market, where prices are determined through negotiation and are influenced by insurer and provider bargaining leverage.

Back in the 1990s, commercial insurers were paying hospitals a rate close to Medicare's rates. Today those prices are more than two and a half times what Medicare pays hospitals for the same services, and in some cases, even more than four times. That kind of growth isn't about offsetting Medicare shortfalls. It reflects the fact that hospitals with significant market power are able to negotiate much higher prices.

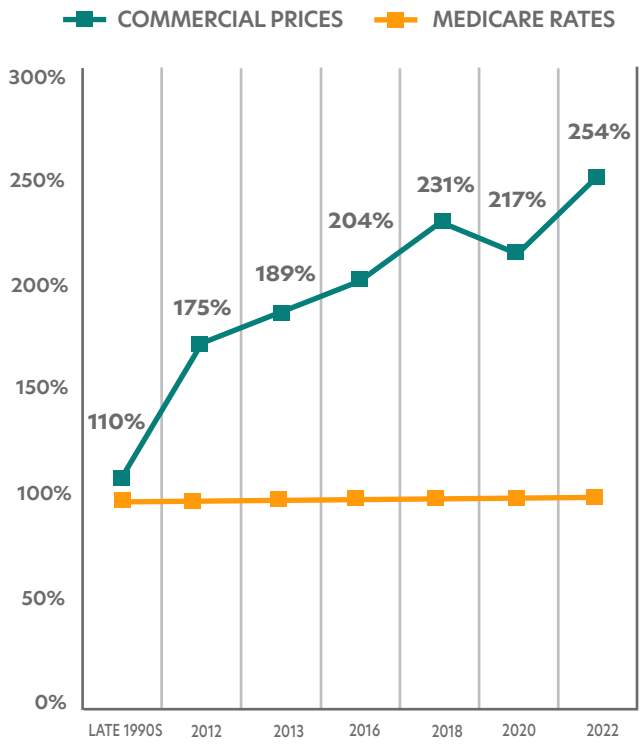
It's also important to remember that Medicare payment rates do go up over time and generally keep pace with inflation. So, the idea that hospitals are being underpaid and have no choice but to shift costs onto commercial payers isn't supported by the data. The real driver here is market dynamics — and in particular, the leverage hospitals have for negotiating higher commercial rates when they face little competition.

MARKET POWER AND CONCENTRATION?[5]

Hospital Relative Prices and Market Share



INPATIENT RELATIVE TO MEDICARE (%)



Q Some assume higher commercial prices reflect better-quality care. Is that true in practice? What have you found in your research?

A No, we don't see a relationship between prices and quality in the research. For example, the RAND Hospital Price Transparency Study examined the relationship between hospital prices and CMS quality star rating[5]. Even among hospitals with five-star quality ratings—the highest rating—some are being paid more than four times what Medicare pays. But at the same time, other five-star hospitals are paid much closer to Medicare's prices. The same is true at lower levels of quality—we see the same variation in prices. So if price reflected quality, we'd expect a strong positive correlation between the two. Instead, the variation tells us something different: higher prices are not about paying for better-quality care. Rather, research shows these high prices are driven by provider market power.

Cost vs quality shows that you can be a two, three or four star rated hospital and the mean price is similar, supporting the lack of correlation between quality rating and price.

Q Explain the benefits of RBP. How does RBP work in practice? Why is Medicare the right benchmark to align to?

A RBP works by tying payments for hospital services to a percentage of Medicare's payment rates. Medicare is a useful benchmark because it's based on a consistent, transparent methodology that reflects the actual resources required to deliver care. Medicare's payment rates also get updated regularly and are broadly accepted as fair baselines, and so, anchoring commercial payments to that standard brings predictability and accountability into the pricing process[6].

For employers, the benefit is straightforward: you're no longer paying whatever rate a hospital can command based on its market leverage. Instead, you're paying a rate tied to a widely recognized benchmark that's grounded in cost and updated over time. That shift can generate substantial savings while still ensuring providers get paid fairly. And because Medicare rates increase and keep pace with inflation, tying commercial payments to them means your plan is aligned with a rational, evidence-based pricing framework.

In our research we found one of the clearest examples of the impact of RBP comes from Oregon, where the state implemented an RBP model for its state employee health plan[7]. The plan capped hospital payments at 200% of Medicare by anchoring payments to transparent, cost-based benchmarks rather than to negotiated commercial rates. The result was substantial savings for the state — and, importantly, savings that were achieved without disrupting access to care. Hospitals continued to participate in the plan, and employees continued to receive services. The Oregon example demonstrates that RBP isn't just a theoretical model. It can meaningfully reduce spending while still ensuring providers get paid fairly and patients maintain access to care.

Roslyn Murray's healthcare reality check: Myths about what is driving costs — and what the data really shows

MYTH:	REALITY:
✖ Consumer overuse of health services is the main reason spending keeps rising.	✔ Rising commercial healthcare spending is driven primarily by hospital pricing power and market consolidation, not by how much healthcare services people use.
✖ Hospitals charge commercial payers more to make up for Medicare underpayment.	✔ Hospitals are not raising prices to make up for Medicare underpayment. Commercial prices have soared from near parity in the 1990s to more than 2.5 times Medicare rates today.
✖ Medicare rates generally stay flat and fail to keep up with inflation.	✔ Medicare payment rates do rise over time and keep pace with inflation, undermining the idea that commercial prices must climb to offset public payment shortfalls.
✖ Higher prices mean better care.	✔ Higher commercial prices do not signal better-quality care. Even among five-star hospitals, payment rates vary widely.
✖ Shifting costs to employees is an effective way to control healthcare spending.	✔ Shifting costs to employees through high-deductible plans doesn't address the root cause of rising healthcare costs — and often worsens affordability for workers, without slowing spending growth.
✖ Moving care outside the hospital will automatically lower costs.	✔ The settings where care gets delivered may be changing, but consolidations of outpatient facilities and physician practices mean pricing power follows hospitals into new care settings.
✖ Benchmarking payments to Medicare will financially destabilize hospitals.	✔ The benchmarking of payments to Medicare through RBP can rein in excessive costs without disrupting employees' access to care.

Closing thoughts

Recent research supports a clear message: resolving the healthcare affordability crisis begins with reframing the problem itself. Strategies focused on reducing utilization or on shifting costs to employees will continue to fall short because they target the wrong lever. The evidence shows that rising commercial spending is driven primarily by hospital market power — not by Medicare underpayment, uncompensated care or better quality[1]. Until leaders confront that reality, even the most-well-intentioned solutions will fail to make meaningful, sustainable progress.

At the same time, there are practical pathways forward. Alternative health plans like RBP, which tie payments to a transparent and cost-based benchmark such as Medicare, demonstrate that it's possible to curb excessive pricing without disrupting employees' access to care. The takeaway is both sobering and hopeful: even strategies that sound transformative haven't changed the pricing fundamentals in the commercial space, yet alternative health plan options like RBP offer a viable path forward that can lower costs for employers while expanding access and options for employees without asking them to accept less.

Sources:

1. Hospital Market Consolidation and Pricing Power

Health Care Cost Institute (HCCI). (2022). 2022 Health Care Cost and Utilization Report. https://healthcostinstitute.org/reports/annual-reports/entry/2022-health-care-cost-and-utilization-report

Centers for Medicare & Medicaid Services (CMS). (2024). National Health Expenditure Fact Sheet. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet

Levinson, Z., Godwin, J., Hulver, S., & Neuman, T. (2024). Ten Things to Know About Consolidation in Health Care Provider Markets. KFF. https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

2. Research by Roslyn Murray and Colleagues

Murray, R. C., Brown, Z. Y., Miller, S., Norton, E. C., & Ryan, A. M. (2024). Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Affairs (Millwood), 43(3).

Milad, S., Murray, R. C., Navathe, A. S., & Ryan, A. M. (2022). Value-based payment models in the commercial insurance sector: a systematic review. Health Affairs, 41(12), 1731–1739.

3. Milad, S., Murray, R. C., Navathe, A. S., & Ryan, A. M. (2022). Value-based payment models in the commercial insurance sector: a systematic review. Health Affairs, 41(12), 1731–1739.

4. Ten Things to Know About Consolidation in Health Care Provider Markets (KFF, April 19, 2024): [kff.org]

5. Whaley, C. M., Briscombe, B., Kerber, R., Oduor, M., & White, C. (2023). RAND Hospital Price Transparency Study, Round 5.1. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1144-5.html

6. Centers for Medicare & Medicaid Services. (2024). Medicare Payment Systems. https://www.cms.gov/medicare/medicare-fee-for-service-payment

7. Oregon State Employee Plan / Reference-Based Pricing (RBP) Policy

Oregon Legislative Assembly. (2017). Senate Bill 1067. https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB1067

Murray, R. C., Brown, Z. Y., Miller, S., Norton, E. C., & Ryan, A. M. (2024). Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Affairs (Millwood), 43(3).

Murray, R. C., Norton, E. C., & Ryan, A. M. (2024). Oregon's hospital payment cap and enrollee out-of-pocket spending and service use. JAMA Health Forum, 5(8), e242614.

About Imagine360

Imagine360 is a leading healthcare solutions provider that helps self-funded employers take control of their healthcare costs while delivering better experiences for members. With more than 18 years of expertise in RBP and health plan administration, Imagine360 develops fully integrated solutions that combine deep industry knowledge, data-driven strategies and concierge-level support for employers. The company partners with employers, brokers and consultants to design and manage customized health plans that lower costs, increase transparency and improve outcomes — without compromising quality or access. Backed by dedicated advocacy, legal protection and proven results, Imagine360 is reimagining what smarter healthcare can look like for organizations and their employees.

Learn more at Imagine360.com or subscribe for more content like this.