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Testimony before the New Jersey Senate Committee on Health, Human Services and Senior Citizens

Comment on S4299 a bill that Creates Health Care Cost Containment and Price Transparency Commission, Office of Healthcare Affordability and Transparency, and Hospital Price Transparency Regulations

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Chairman Vitale and members of the committee, thank you for the opportunity to speak with you today on the critical issue of healthcare affordability. I am Joel Cantor, a Distinguished Professor of Public Policy and the founding Director of the Center for State Health Policy at Rutgers University. The Center conducts rigorous, impartial research to support evidence-based health policy decisions. The Center is non-partisan, and since our founding in 1999 we have worked with every New Jersey gubernatorial administration and routinely conducted analyses to inform legislative deliberations in the state.

Today, I seek to provide background and recommendations as you consider whether, and in what form, to establish the Health Care Cost Containment and Price Transparency Commission and codify the Office of Healthcare Affordability and Transparency (OHCAT) in statute.

In the interest of full disclosure, I have served as technical advisor to the New Jersey Health Care Affordability, Responsibility, and Transparency (HART) cost growth benchmark program since early 2021. The HART program would be an integral component of the work of the proposed Commission. My testimony today reflects my professional views alone and is independent of my HART program advisory role. It also is not intended to represent views of Rutgers University or the funders of our work.

The Challenge of Healthcare Affordability

As you are aware, achieving affordable access to healthcare is a persistent and pressing challenge. States are uniquely well positioned to lead in addressing this issue. In my view, three features are critical to any state-led effort to control healthcare cost growth and advance healthcare affordability:

1. An oversight process, established in statute, that is independent of healthcare industry interests
2. A robust infrastructure to monitor spending trends, analyze cost drivers, and assess market conduct

3. Enforcement authority to ensure accountability and meaningful cost containment while avoiding unintended consequences

Drivers of the Affordability Problem

The United States spends about twice as much per capita on healthcare as the average of other developed nations–without achieving superior health outcomes. New Jersey ranks 11th in cost per capita within the US. Evidence overwhelmingly points to high prices for healthcare services, not excessive use, as a main cause of our cost disparity.[1,2] In fact, Americans use fewer hospital and doctor services than citizens of other wealthy countries, yet we spend much more per capita.

Other factors like population aging and poor health habits contribute only modestly to annual cost increases. What truly sets the US apart is how prices paid to providers are set in commercial health insurance, primarily through negotiations between health systems and insurance companies. This leads to prices that are disconnected from the value of care.

Health systems–which typically own multiple hospitals, numerous physician groups, and rehab or nursing facilities–have consolidated their market power in recent years through mergers and acquisitions, enabling them to significantly raise prices. At the same time, insurance companies often lack sufficient market leverage or the incentive to negotiate affordable rates with large health systems.

Hospital care accounts for about one-third of all healthcare spending and is among the fastest growing segments. From 2022 to 2023 nationwide, hospital spending grew by 10.3%, outpacing overall spending growth of 7.5%.[3] Unlike prescription drugs (another segment with high spending growth), where pricing is mainly determined in national markets, hospital prices are shaped by local market conditions–where states have the most direct regulatory leverage.

Evidence from New Jersey

At the Center for State Health Policy, we study the forces that impact healthcare efficiency and effectiveness. In a recent study using official New Jersey hospital cost reports, we examined consequences of health system mergers and acquisitions from 2009 to 2020. Our analysis showed that rising hospital profitability closely tracked market consolidation–and that profitability growth was driven mainly by price hikes.[4]

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[1] Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Affairs. 2019 Jan 1;38(1):87-95.

[2] Cooper Z, Craig SV, Gaynor M, Reenen JV. 2019. The price ain't right? Hospital prices and health spending on the privately insured. Quarterly Journal of Economics 134(1): 57-107.

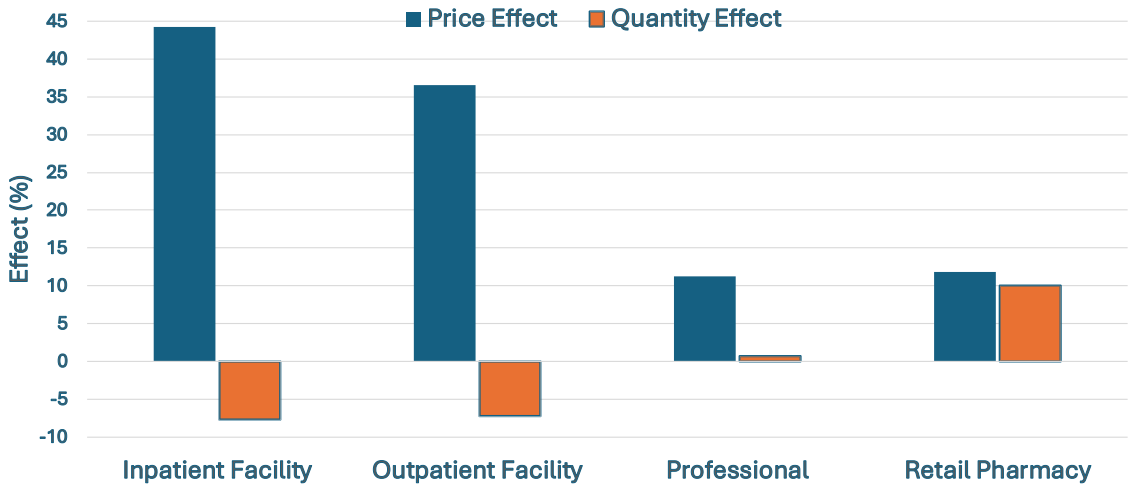
[3] Martin AB, Hartman M, Washington B, Catlin A, National Health Expenditure Accounts Team. National Health Expenditures In 2023: Faster Growth as Insurance Coverage and Utilization Increased: Article examines National Health Expenditures in 2023. *Health Affairs*. 2025 Jan 1;44(1):12-22. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01375

[4] Lu R, Chakravarty S, Wu B, Cantor JC. Recent trends in hospital market concentration and profitability: the case of New Jersey. Journal of Hospital Management and Health Policy. 2024 Mar 30;8. Available at: https://eprints.lse.ac.uk/122700/1/Lu_recent_trends_in_hospital_market_concentration_published.pdf

Our study found that 71% of hospital admissions in New Jersey in 2020 were in "highly concentrated" markets, as defined by federal antitrust authorities. These trends raise serious concerns about future affordability, underscoring the need to develop sustained capacity to monitor market dynamics, curb anticompetitive practices, and moderate cost growth.

Findings of the first New Jersey HART program cost driver report are consistent with our research and national trends. As shown in the chart below, even as utilization per-capita of hospital inpatient and outpatient services declined in New Jersey hospitals from 2016 to 2021, average prices for these services increased substantially, by 44 percent and 37 percent, respectively. Changes in prices and quantities of professional visits (e.g., doctor visits in settings other than hospital outpatient departments) and retail pharmacy services also contributed to cost growth during this period, but at much slower rates.

Total percentage change in price and quantity per-person by category of service, 2016–2021



Source: Exhibit III.1 in Health Care Spending Trends for New Jersey Residents with Commercial Insurance, 2016-2021. https://www.nj.gov/dobi/division_insurance/HART/reports/HealthCareSpendingTrendsNJResidentsCommercialInsurance2016_2021.pdf

Early evidence from healthcare cost benchmarking initiatives in other states suggests that the ability to enforce cost growth limits—through meaningful sanctions—is crucial. The record is clear: voluntary restraint from healthcare providers has never successfully led to sustained cost containment. With the right incentives, however, hospitals can continue to deliver world-class care and stay financially sound without unduly burdening families and employers.

Building an Effective Oversight Framework

An effective and balanced market oversight strategy must include:

- **Independent governance:** Oversight should be led by a board insulated from undue political and industry influence. Membership should include independent experts,

employers, unions, and consumer representatives – those who ultimately bear the cost of healthcare. Providers and insurers should have voices in the process but not voting power.

- **Robust infrastructure and data**: The independent oversight board must be supported by expert staff and have access to comprehensive data. New Jersey should establish an **All-Payer Claims Database** (APCD), a foundational tool that allows for rigorous cost analysis. Nearly half of US states, including New York, Texas, Florida, and California, already operate APCDs. All states operating healthcare cost benchmarking programs – except New Jersey – extensively rely on their APCDs. An APCD is *not* included in S4299, and I urge the Committee to add it to the bill or introduce other legislation to create this vital resource.
- **Enforcement authority**: Massachusetts, which has the longest-running healthcare cost benchmark program, shows that merely naming entities with excessive cost increases offers only temporary relief. The most promising state programs use a staged enforcement approach—starting with identifying healthcare entities that exceed cost benchmarks, requiring corrective action plans when high costs persist, and imposing penalties if corrective efforts are not made in good faith or are ineffective.

Moving Beyond the HART Program

New Jersey's HART program, established by Executive Order in 2021, has made significant strides. It assembles important data and has produced the state's first spending benchmarks and cost driver analyses. However, the HART program relies on fragmented data, lacks the authority needed to drive meaningful change, and is not established in law.

HART has illuminated the problem–but cannot by itself solve it. Without stronger legislated action, healthcare cost growth will continue to erode wages, increase family debt burdens, strain employers, and constrain resources for other vital public priorities.

Conclusion

In summary, addressing healthcare affordability requires an independent, well-resourced, high functioning, and empowered oversight framework. By building on the foundation laid by the HART program, S4299 would go a long way toward strengthening New Jersey's approach to promoting healthcare affordability. New Jersey can be a national leader in making healthcare more affordable for employers, families, and communities.

Thank you for your time and the opportunity to contribute to this important discussion.