



**Something Needs to Happen:**

# What employees think employers should do about health care providers' prices

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2023

# Introduction

The prices charged by hospitals and other health care providers are major **drivers of growth** in health care spending. From 2016 to 2020, **inflation-adjusted prices** grew nearly 25 percent for inpatient services and nearly 18 percent for outpatient services.

**Most employers believe** health care spending negatively impacts their competitiveness and limits their ability to increase employees' compensation. They can try to address high provider prices by changing the design of employee benefits. But after decades of rising premium contributions and cost sharing, employees may see any such changes as shifting even more spending onto them. Employers can also advocate for state and federal regulation to address prices, but they may wonder whether their employees want them to play that role.

Public Agenda, with support from Arnold Ventures, set out to learn how employees understand health care costs and how they see employers' roles in addressing providers' pricing through benefit design and policy advocacy. In January and February 2023, Public Agenda conducted five focus groups with beneficiaries of employer-based insurance and conducted in-depth interviews with selected focus group participants.

The methodology section of this report provides details about the focus groups and interviews. The report concludes with avenues for further research and employer engagement.



# Findings in Brief

## 1.

Focus group participants were enthusiastic about government action to control providers' prices but raised concerns about changes to benefit design. They wanted employers to advocate for government action but doubted they would or could do so.

- ◆ Government regulation of providers' prices and the limiting of hospital mergers both attracted strong support in these focus groups.
- ◆ Participants saw price regulation as a way to make pricing more reasonable and predictable. They saw limiting mergers as a way both to control prices and protect quality by checking hospitals' power.
- ◆ In principle, participants supported employers' advocating for government action to control providers' prices. But they questioned whether small employers have enough power and whether large employers have enough incentive to do so.

## 2.

Of the three benefit designs participants considered, they favored reference pricing over adopting tiered networks or eliminating coverage for low-value providers, both of which, they believed, would adversely affect access. They did not trust insurers to measure quality.

- ◆ Participants favored reference pricing, which they saw as a way to make pricing predictable with minimal impact on access. But they worried it could leave providers with less cash flow and fewer incentives to provide high-quality care.
- ◆ Tiered networks sparked concern. Participants saw tiering as having the potential to maintain access, but they worried that it would make care more expensive for people who cannot travel to preferred providers.
- ◆ Eliminating in-network coverage for low-value providers was not popular. Participants saw it as limiting access, especially for low-income people, people of color, and rural communities.
- ◆ Participants did not trust insurers to decide which providers should be categorized as low- or high-quality in tiered or narrow networks.

# 3.

Participants underestimated how much providers' prices drive growth in health care spending and how much employers contribute to premiums. When presented with data, they reasoned that providers' steep price increases must be driven by greed.

- ◆ Initially, focus group participants blamed inflation, insurers, and pharmaceutical companies for high health care costs more than they blamed providers.
- ◆ When presented with data, participants were surprised to learn insurers and pharmaceutical companies account for relatively low proportions of health care spending. They were also surprised that providers account for a relatively large share of spending and that providers' prices have increased so steeply. But these trends fit with their view of the health care system as greedy in general.
- ◆ Participants initially believed employees pay the bulk of their own insurance premiums, but they understood that both employers and employees are affected by costly premiums.

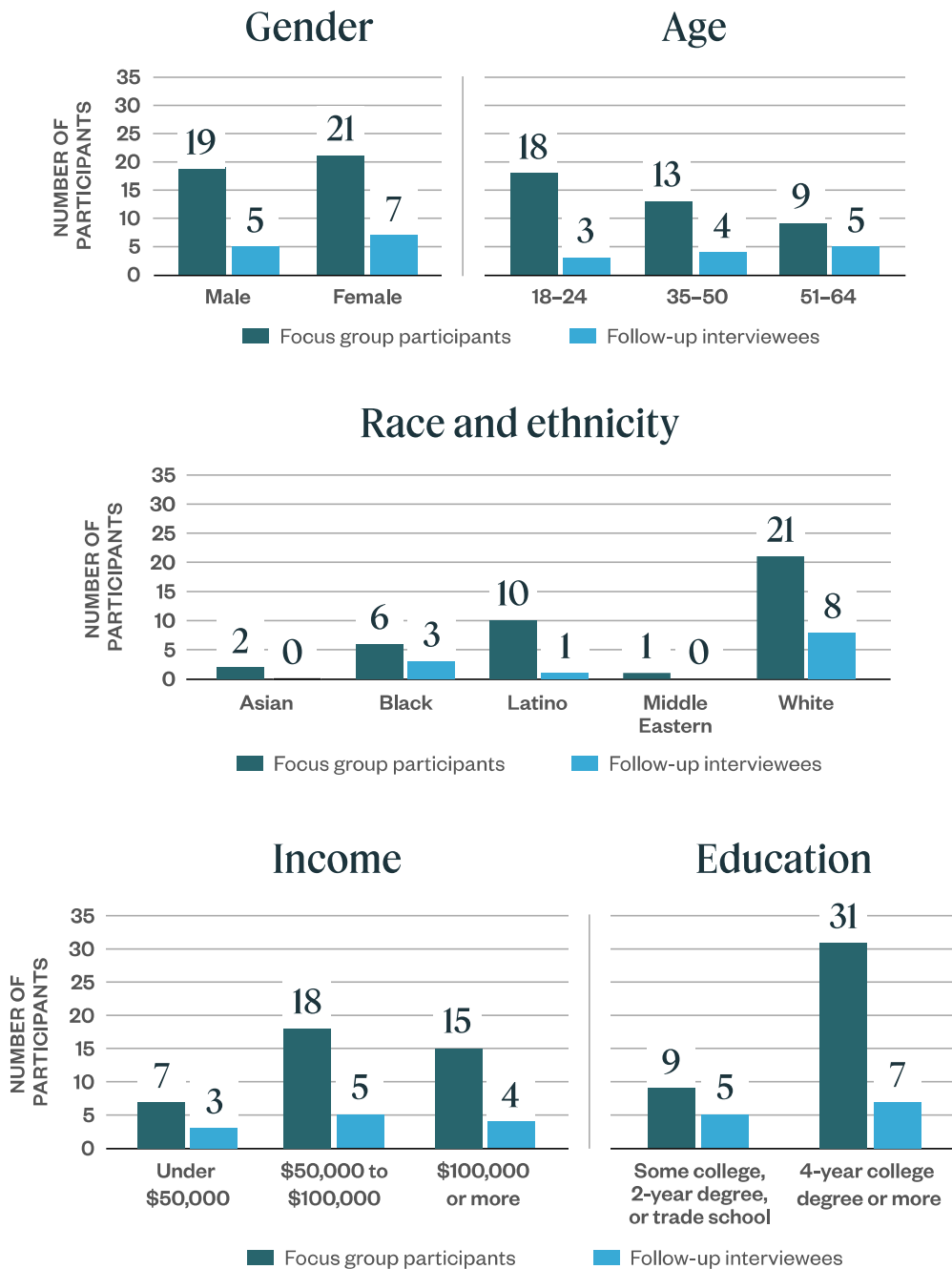
To learn more about these findings, go to <https://www.publicagenda.org/reports/employee-health-care-2023/> or email [research@publicagenda.org](mailto:research@publicagenda.org).

This research is supported by Arnold Ventures.

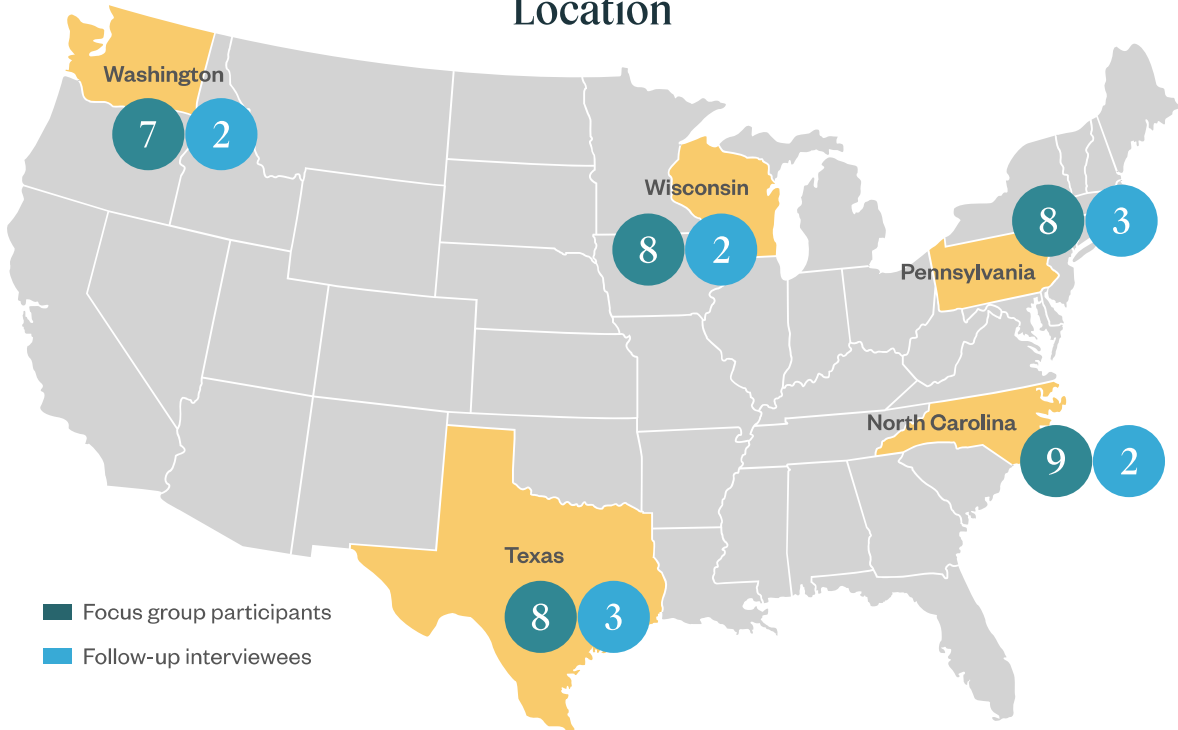
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# Research participant characteristics

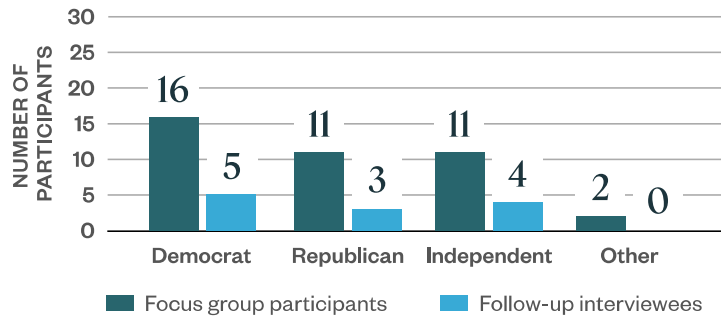
Public Agenda conducted five focus groups with a total of 40 people, all of whom were covered by employer-based health insurance from their own employers, not that of a spouse or parent. Public Agenda conducted follow-up interviews with twelve of the focus group participants.



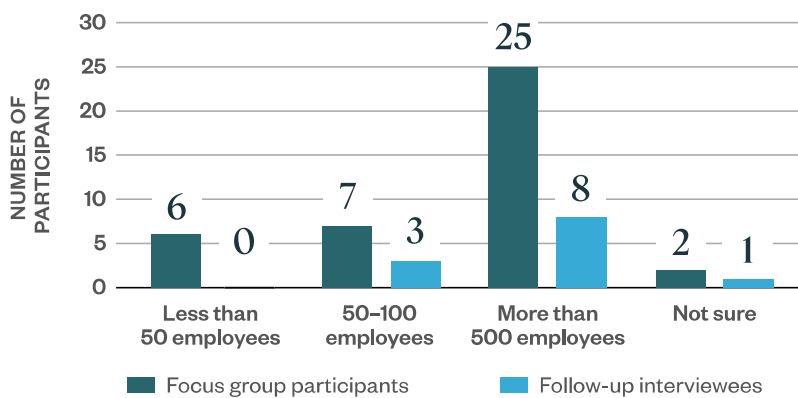
## Location



## Political affiliation



## Participant-reported employer size



# 1.

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Focus group participants were enthusiastic about government action to control providers' prices but raised concerns about changes to benefit design.

**They wanted employers to advocate for government action but doubted they would or could do so.**

At the beginning of each focus group, the moderators shared data with participants about the distribution of health care spending across categories and about changes in spending, utilization, and prices over time. The participants' responses to those data, detailed in section three of this report, informed their discussion of government action to control health care spending and of benefit design.

**Government regulation of providers' prices attracted strong support in these focus groups, with participants seeing it as a way to make prices more reasonable and predictable.**

Moderators briefly explained price regulation to focus group participants, mentioning the example of **Maryland's hospital rate-setting system**. Participants expressed support for price regulation, which they saw as a way to protect people from what they framed as price gouging and to make pricing more rational.<sup>1</sup>

“If there were an unbiased and fair way to keep pricing regulated, that would be great. I did an emergency room visit. I know how much work the doctor put in, literally just saw me for fifteen minutes. The bill, \$800. Sometimes it just is blatantly ridiculous.”

Texas focus group participant, Latina, in her mid-20s

“The state should be able to cap those types of increases. That's the kind of thing the government should be doing for us. The government should have a place to protect those in the state of Wisconsin to make sure that they're not bankrupting people.”

Wisconsin focus group participant, white, in her early 30s

“Setting some sort of federal rate that's adjusted for geographic area and adjusted annually for inflation—that is the government's role, to get involved and make sure the prices are reasonable, especially when they're more monopolistic year after year.”

North Carolina focus group participant, white, in his late 40s

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<sup>1</sup> Focus group quotes have been minimally edited for clarity.



Participants often mentioned their wariness of government regulation in general. But they felt regulation is now warranted because prices have gotten out of hand. While they more often expressed comfort with state than with federal price regulation, that preference was not universal.

“I don’t like overstepping. I think the state government over the federal government should have some power to stop increased inflation like this in hospital services. Maybe not regulating how much [hospitals] charge for each procedure or don’t micromanage, but stop overall prices from going up 200-plus percent in twenty years.”

Wisconsin focus group participant,  
white, in his mid-20s

“We’re talking about something lifesaving that has become unreachable because of the expense of it. I’m not sure that government intervention is what should happen, but something needs to happen. Something needs to be regulated or changed.”

Wisconsin focus group participant,  
white, in her early 60s

“I just don’t think I could trust the federal government. I would rather look at the people in my community and have faith that we all have kind of the same needs and goals.”

Pennsylvania focus group participant,  
Latina, in her mid-40s

“The federal government should be the one who regulates, otherwise you’re gonna have at least fifty states having completely different rules.”

Pennsylvania focus group participant,  
Latino, in his early 50s

Participants saw regulation as a way to make pricing less confusing and more transparent, something they felt is missing when they seek care.

**“If my insurance company wants a pretreatment estimate, [the provider] can give them exactly how much it’s going to cost. But they can’t tell me? I should be able to get upfront pricing. I should know how much it’s going to cost before you treat me, not after.”**

**North Carolina focus group participant, Black, in her mid-40s**

**“Patients should be able to know what they’re going to pay for a service before they nod their head yes in the doctor’s office. How they’ve gotten away with not being able to tell people what they’re charging and then just charge them on the back end is beyond me.”**

**North Carolina focus group participant, white, in his late 40s**

While opposition to price regulation was limited, participants wondered how it would work. They raised the possibility of hospitals and their corporate owners unduly influencing the rate-setting process. They also mentioned concerns about rates being set too high and causing lower-priced providers to raise their prices. The costs of regulation itself also came up as a potential downside of price regulation.

**“What stands in the way of having regulation? It’s political contributions—generally called corruption.”**

**Texas focus group participant, Latino, in his mid-30s**

**“Regulations increase costs. When we add regulations in any area, then we have administrative costs, we’ve got recordkeeping costs, we’ve got a cost to the government to have government employees who are now going to be the regulators and enforcers.”**

**Texas focus group participant, white, in his mid-50s**

To the extent that participants had concerns about government price regulation, they did not seem to be based on ideology. Instead, they seemed driven by a sense that government entities cannot do a good job of anything, let alone something as complex as regulating health care prices.

**Has anyone ever tried to call the IRS? The quality that the government offers is just horrendous. I've had bad experiences over and over and over again with anything government related. Let's save everybody that headache of the government taking over one more thing that they can't even handle.**

**Pennsylvania focus group participant, Latina, in her early 30s**

**The limiting of hospital mergers also attracted strong support. Participants saw it as a way both to control prices and protect quality by checking hospitals' power.**



The moderators shared examples of hospital mergers and consolidation in participants' states and asked whether the government should play a greater role in regulating them. Support was strong and opposition quite limited. Participants' primary reasons for supporting the regulation of mergers included breaking up what they called monopolies and protecting people from what they framed as price gouging.

**“Back in the day, this would have been thought of as creating monopolies, plain and simple.”**

**Pennsylvania focus group participant,  
Latino, in his early 50s**

“I’m one of those market people. I think the market should make these decisions. But when you have one big giant and they hold a monopoly on health care, we don’t have a choice. They can charge whatever they want because there’s nobody else around.”

**Texas focus group participant, white, in his mid-50s**

“If you’re gonna get on Google and Apple and Microsoft for being a monopoly, then how can you not go after health care? That’s way more important than a computer or iPhone.”

**North Carolina focus group participant, Black, in her mid-40s**

Some participants reported declines in the quality of care which they attributed to mergers in their regions. They saw regulating mergers as a way to protect quality, because they reasoned that competition creates incentives to provide higher-quality care and better patient experience.

“My doctor has actually joined in with [a large hospital system], and his prices have increased quite a bit. His office is nothing like it used to be. And I feel like he has no control of his office anymore. He really isn’t there to help people. He has to see as many people as possible and to make the stockholders as much money as possible.”

**Texas focus group participant, white, in her mid-40s**

While participants rarely expressed opposition to regulating mergers, they tended to favor state rather than federal regulation because they believed health care markets are unique in each state. They also felt progress is more easily achievable in state than in federal policy.

**“What might work in New York and New Jersey, California, is very different from what Wyoming and Montana need and Mississippi, right?”**

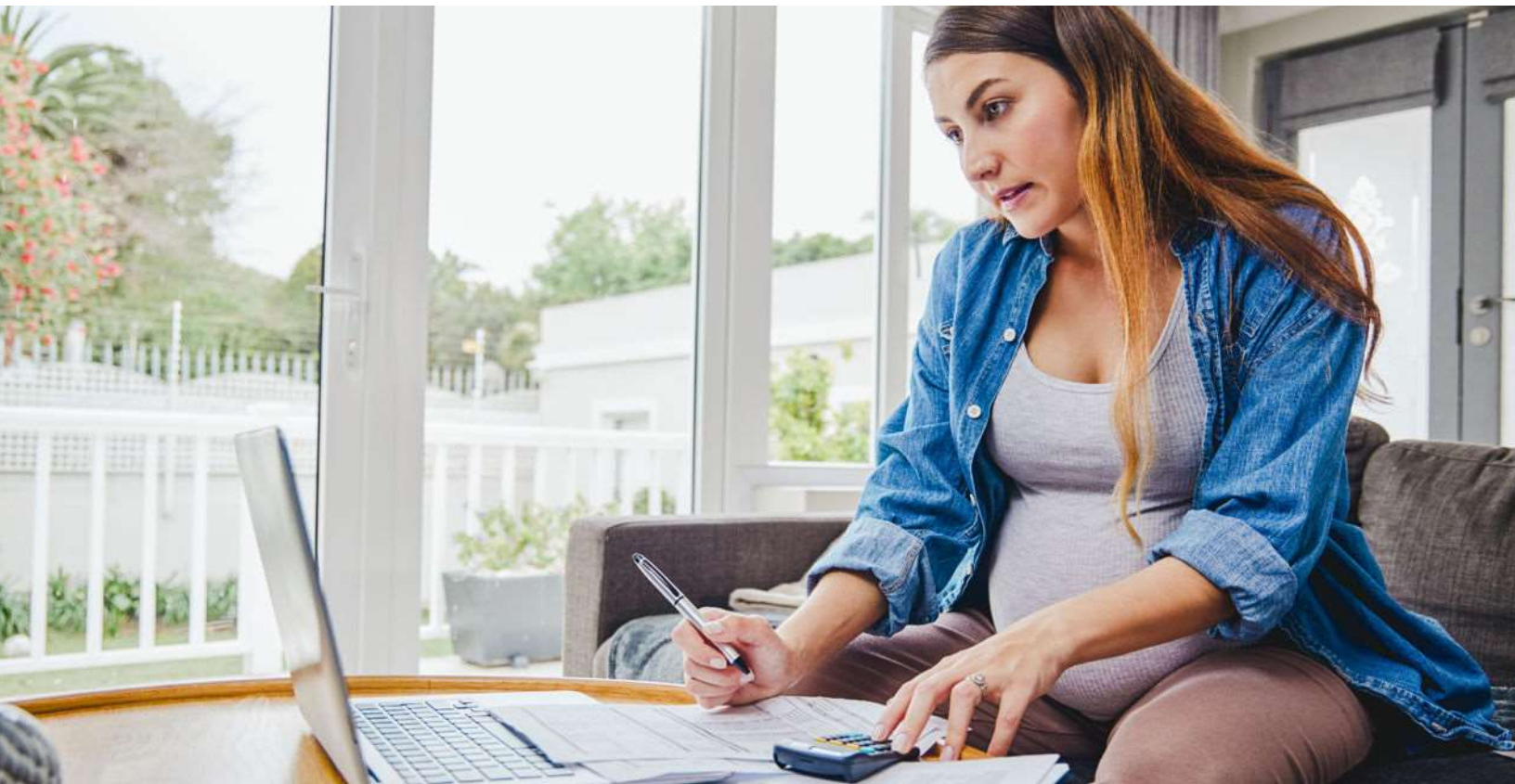
**North Carolina focus group participant, white, in his late 40s**

**“We definitely have better luck at the state level, I think, than trying to go federal. I feel like your state representatives are more accountable to you than your federal ones.”**

**North Carolina focus group participant, Black, in her mid-40s**

**“Trying to get something together at the federal level has proven so difficult at this point. The state is our best chance.”**

**North Carolina focus group participant, Black, in her mid-20s**



**In principle, participants supported employers' advocating for government action to control providers' prices. But they questioned whether small employers have enough power and whether large employers have enough incentive to do so.**

The moderators asked participants whether employers in general and their own employers in particular should play larger roles in advocating for policies to address high provider prices. While there was no opposition per se, participants often mentioned that small employers are limited in their capacity and power to push back against high prices.

“I have a small, twenty-person office. Ultimately, who in my particular office would have the time to be the advocate? It would have to be a dedicated position of employee liaison to the government. But perhaps maybe in a bigger office with more people that's probably feasible.”

Texas focus group participant, Latina, in her mid-20s

“When you've got a group of companies, that leverage that they have against these prices just got way bigger. If I were talking to my HR director, I would say you need to go find somebody that you can put heads together [with] on this and form a coalition or something to try and work on this.”

Wisconsin focus group participant, white, in his mid-30s

Participants questioned whether employers actually have incentives to address high provider prices. They noted the employers may not really care about the costs their employees face and may be too focused on insurance premiums to pay attention to the providers' prices that underlie them.

They have an incentive to keep premiums down. I don't think they're going to do the same thing for hospital costs because at the end of the day those hospital costs don't affect their bottom line.

North Carolina focus group participant, Black, in her mid-40s

At the end of the day, it's a choice that these companies are making, and the choice rarely goes in our favor.

Pennsylvania focus group participant, Latino, in his late 20s

Participants also thought employers, particularly large employers, might not want to antagonize insurers or hospitals with whom they have business or personal relationships.

“There’s a lot of incestuous relations between a lot of the CEOs and board members and the companies who have a vested interest in seeing the status quo continue because it’s been successful for them.”

North Carolina focus group participant, white, in his late 40s

“If you’re talking to your own employees and you say I want to lower health care costs or insurance costs, you’re going to have a lot of people on your side. But if you go talk to insurance companies and hospitals, that’s a more difficult conversation.”

Wisconsin focus group participant, white, in his mid-20s

Despite these concerns, participants understood that efforts by employers to address high provider prices would ultimately benefit the employers’ own bottom lines.

“They’re paying more for premiums than the employees are paying. So you would think that they would want to be more interested in keeping health care prices down just for that reason alone.”

North Carolina focus group participant, white, in his late 40s

“If they’re able to drive those prices down and provide quality insurance, they’ll be able to keep quality employees around longer.”

Wisconsin focus group participant, white, in his mid-30s

# 2.

Of the three benefit designs participants considered, they favored reference pricing over adopting tiered networks or eliminating coverage for low-value providers, both of which, they believed, would adversely affect access.

**They did not trust insurers to measure quality.**



The moderators presented participants with three approaches employers are using to address high provider prices: reference pricing, tiered networks, and narrow networks that do not cover low-value providers. The moderators briefly explained each approach in layperson's terms, shared arguments for and against each, and asked participants to rank which they preferred most and least. The goal of having the participants rank was not to quantify their support precisely but to spark conversation about the reasoning, concerns, and priorities that motivated participants' preferences.

**Participants favored reference pricing, which they saw as a way to make pricing predictable with minimal impact on access. But they worried it could leave providers with less cash flow and fewer incentives to provide high-quality care.**

Participants consistently ranked reference pricing as the top choice among the three approaches to benefit design they were asked to consider. Moderators explained reference pricing as using Medicare payment rates to determine how much to pay hospitals and doctors. Reference pricing seemed to address participants' frustrations with what they saw as irrational pricing and billing. Those who favored it frequently mentioned it would make pricing more predictable and care more affordable and accessible.

“Whether it was realistic or not, I just liked the fact that it was targeting what I felt was the root of the problem, which was cost being out of control.”

Texas focus group participant, Latina, in her mid-20s

“Having a baseline to keep all hospitals somewhat in the same area is important. I think keeping them all generally around the same price is important.”

Wisconsin focus group participant, white, in his mid-20s

“At least you know what you're getting yourself into in advance. You know what you're paying ahead of time.”

North Carolina focus group participant, Latino, in his mid-20s

Participants who favored reference pricing thought it would preserve access to more hospitals and doctors than tiered networks or eliminating coverage for low-value providers. Among their concerns, however, was that hospitals and doctors might refuse to treat patients whose insurers use reference pricing, which ultimately could limit access.

“The only con that I would see is that maybe doctors wouldn’t want to see the patients that were contracted with certain insurance companies. But I guess if all the insurance companies did this, then it would work.”

**Pennsylvania focus group participant, Latina, in her early 30s**

“This has huge potential of limiting where you can actually have the choice to go based on who is going to even accept your insurance.”

**Wisconsin focus group participant, white, in his mid-30s**

Participants also expressed concern that hospitals and doctors would earn less money under reference pricing and therefore have less incentive to provide high-quality care. Behind this concern seemed to be a belief that providers, including individual clinicians, are driven by profit.

“These doctors are human beings. Do you think they’re going to spend more time with a person whose visit is going to get them \$12 or the one that’s going to get them \$200?”

**North Carolina focus group participant, white, in his late 40s**

“I would have a big concern about the level of actual quality care you’re going to get, because stuff’s still going to cost what it is and so they’re going to try and do the bare minimum in my opinion, use the lowest quality materials, use the least qualified people to be able to maintain those costs and still try and turn a profit.”

**Washington focus group participant, white, in his mid-30s**

Participants were also concerned that if prices were set too low, hospitals' cash flow would be limited, and quality could decline.

**“You would get a lot of people that would be understaffed and more burnout. With that, you may get less quality care.”**

Wisconsin focus group participant, white, in her early 30s

**“You would have a talent bleed from the reference-price hospitals to the more expensive hospitals because they could afford to pay their doctors and staff more.”**

Texas focus group participant, white, in his mid-50s

Finally, participants were concerned that reference pricing is just not realistic because providers will never accept lower rates.

**“It would be ideal to have reference pricing if everybody could. [But] I don't think that people or hospitals will agree to it. I don't see it happening, even though it should.”**

Wisconsin focus group participant, white, in her early 30s

**Tiered networks sparked concern. Participants saw tiering as having the potential to maintain access, but they worried that it would make care more expensive for people who cannot travel to preferred providers. Participants did not trust insurers to decide which providers are of high quality.**

The moderators described tiered networks to participants as a system in which employers set up insurance plans so employees pay less out of pocket if they go to the best hospitals and doctors but pay more to go to hospitals and doctors that provide lower-quality, overpriced care.



Rather than embracing tiered networks wholeheartedly, participants saw it as a lesser evil that would preserve access to more hospitals and doctors than eliminating coverage for low-value providers would.

**“You still have the option to go to where you want to, you can make that choice to pay more or pay less and determine what’s kind of the best for you.”**

**Washington focus group participant, white, in his mid-30s**

**“I like to have options and know if I can pay or not. Give me the options to choose what I want and still have wide coverage.”**

**Texas focus group participant, Middle Eastern, in his late 30s**

Nonetheless, core concerns about tiered networks included the potential to adversely affect access and affordability as well as mistrust of how insurers would measure quality. Participants felt tiering would exacerbate what they saw as already limited access, particularly for emergency care and particularly in low-income communities, communities of color, and rural communities.

**“I personally would be fine with either of these. But it would impact a lot of poor people and a lot of Black and brown people. [It] has them going to a hospital where the people who have the least money are going to end up having to pay more.”**

**North Carolina focus group participant, Black, in her mid-40s**

**“I do feel bad for any of the people who are in smaller towns because if you’re in the boonies where you only have one hospital that’s an hour and a half away and they don’t cover that, you’re going to have to then go five hours to a hospital.”**

**Pennsylvania focus group participant, white, in his early 40s**

**“If something happens where I fall and slip on the ice, I don’t want to be stuck paying a bunch of money because the closest hospital to me is not covered.”**

**Wisconsin focus group participant, white, in her early 30s**

Participants did not trust insurers to judge which hospitals or doctors provide high-quality care. They felt insurers would drive people toward inexpensive, but not necessarily high-quality, care and would not prioritize patients' needs.

“What’s the definition of quality care and why is the CEO of XYZ insurance company deciding that this is where I need to go with my family?”

Wisconsin focus group participant, white, in his mid-30s

“With any type of system where someone is judging, there’s always corruption.”

Texas focus group participant, white, in her mid-40s

“With the insurance companies making these decisions about what is a good hospital, that’s just who they’re going to make the most money from, so it could actually be the worst hospital. And they’re gonna not care where you necessarily live.”

Pennsylvania focus group participant, white, in his early 40s

**Eliminating in-network coverage for low-value providers was not popular. Participants saw it as limiting access, especially for low-income people, people of color, and rural communities. Again, they did not trust insurers to measure quality.**

The moderators described this approach to benefit design as a system in which employees pay less out of pocket if they go to the best hospitals and doctors, but the hospitals and doctors that provide lower-quality, overpriced care are out of network. Opposition to this approach was intense compared with opposition to the other two options. When participants ranked the three approaches, this was consistently last. In rare instances, participants said they could accept it if it very significantly brought down their costs.

The reason my health care has gone down is because our company actually did something like this. Right now, I pay zero for health coverage. But you are very restricted on where you’re able to go.

Texas focus group participant, white, in her mid-40s



As with tiered networks, concerns about access and affordability were key and intertwined. Participants again noted that travel time and transportation costs already limit access to in-network providers. They noted that low-income people, people of color, and rural communities already would be least able to travel to in-network providers and therefore most likely to face high out-of-network charges. These concerns were particularly acute with regard to complex care and emergencies.

“For me [this option] is just an absolute no. I know exactly where the medical practices would get shut down: in the areas of town where people that look like me are. And I’m not having that. I would fight tooth and nail against that because I’ve already seen that happen. The nice doctors’ offices are going into midtown, and people who look like me do not live there.”

North Carolina focus group participant,  
Black, in her mid-20s

“If you’re talking about insurance companies deciding what hospitals or doctors are offering valuable care and good care, let’s be honest, it’s probably not going to be in the lesser privileged communities. And those people who don’t have transportation, they’re going to go to the local hospital, and then what? They get stuck with the whole bill out of pocket because they just happen to be, unfortunately, close to a hospital that’s not the greatest. Seems unfair.”

North Carolina focus group participant,  
white, in his late 40s

Participants again mistrusted insurance companies to measure quality. As with tiering, they were concerned insurers would prioritize cost over quality, and that hospitals and their corporate owners would use their money and influence to convince insurers to classify them as high-quality.

“I see the word “quality” being thrown around a lot. I don’t know where quality is being determined from. You never know the shady dealings that are going on.”

Pennsylvania focus group participant, Latina, in her early 30s

“The big thing for me is trust. We keep talking about best value, best quality, and it’s like, okay, well, I need to trust the people who are making those determinations.”

Pennsylvania focus group participant, Latina, in her mid-40s

“Quality care is so subjective. How does somebody choose what quality care is for everybody?”

Wisconsin focus group participant, white, in her early 60s



# 3.

Participants underestimated how much providers' prices drive growth in health care spending and how much employers contribute to premiums.

When presented with data, they reasoned that providers' steep price increases must be driven by greed.





**Initially, focus group participants blamed inflation, insurers, and pharmaceutical companies for high health care costs more than they blamed providers.**

At the beginning of each group, before they discussed government action to control prices or changes to benefit design, the moderators asked participants whether they had noticed their health care costs increasing in recent years—in the form of higher premiums, copays, deductibles, or other cost sharing—and, if so, why they believed costs had increased. Participants rarely reported that their costs had decreased, and those who did typically said they felt lucky. Participants most often cited inflation, insurance companies, and pharmaceutical companies as the causes of high costs. Rarely did they blame health care providers.

“I’d assume just with everything going up, health care is going to go up with that as well. It just seems like it does every year. Unfortunately, it seems like it outpaces inflation.”

Texas focus group participant, Latino, in his early 40s

“Part of the reason why health care is getting more expensive is a combination of things. I definitely think it’s labor costs. I think there are probably shortages in some places.”

Washington focus group participant, Afro-Latina, in her late 20s

Participants also often noted that entities or institutions in the health care system had responded to inflation by passing high prices on to patients. In fact, accusations of greed ran through participants' explanations for high costs. Participants were not necessarily clear about which entities or institutions were being greedy, but they seemed to see the entire health care system as prioritizing profits over patients.

**“I feel like greed and profit is the main reason health care costs have gone up.”**

**Wisconsin focus group participant, white, in her early 60s**

**“I believe that there is an inflationary aspect to it, but I also believe there’s a corporate greed aspect to it as well. If you’re trying to always maximize profits, that money’s gotta come from somewhere, and that comes from the consumer.”**

**North Carolina focus group participant, Black, in her mid-40s**

Participants routinely blamed insurance companies for the high costs they had experienced. Pharmaceutical companies also came in for scorn. Occasionally, the participants blamed the requirement under the Affordable Care Act that insurers cover people regardless of age or preexisting conditions, with some proposing that these coverage requirements contribute to higher premiums.

**Insurance companies are the ones driving the prices.**

**Pennsylvania focus group participant, Latino, in his early 50s**

**I think the biggest problem is Big Pharma and the price of pharmaceuticals.**

**Texas focus group participant, white, in his late 50s**

**The executives at these major drug companies are making these outrageous salaries and then bonuses beyond that. A lot of Americans are struggling to even pay their health care bills, and these companies are walking away with financial sums that are not right, in my opinion.**

**Wisconsin focus group participant, white, in his mid-30s**

Participants rarely singled out hospitals and other health care providers for driving high costs or for setting prices too high, per se. Instead, when discussing providers, they focused on billing practices, which they described as purposefully convoluted, confusing, and opaque.

“I feel like it is just plain old corporate greed, plus the system is totally convoluted. When you go to one facility to get something done, you’re billed from five different places.”

Pennsylvania focus group participant, Black, in her late 50s

“The system here is very inefficient. Doctors, whenever they treat you, every single item is a barcode instead of the whole treatment. When my wife gave birth, literally every pill she got, every item, every bandage, everything was scanned.”

Texas focus group participant, Middle Eastern, in his late 30s

**When presented with data, participants were surprised to learn insurers and pharmaceutical companies account for relatively low proportions of health care spending. They were also surprised that providers account for a relatively large share of spending and that providers’ prices have increased so steeply. But these trends fit with their view of the health care system as greedy in general.**

The moderators shared a pie chart with focus group participants, showing the distribution of health care spending in 2020 across categories—including hospital care; doctors, dentists and other individual providers; public health; nursing homes and home care; prescription medication; over the counter medication; insurance costs; and government administrative costs—based on [national data from the California Health Care Foundation](#). As they made sense of the chart, participants asked engaged questions, including about how spending was categorized, the roles of different payers, variations in spending for people with differing health care needs, and comparisons with other countries.

Participants expected net spending on insurance to be higher than it actually is. They did not have a clear understanding of the roles of payers, providers, and purchasers in the health care system—nor should they be expected to understand such a complicated system. In particular, they had trouble grasping that the data they were looking at showed the net cost of health insurance, rather than the payments that flow through insurers.

“I was a little surprised at the insurance companies. I thought that that would have been a larger piece of the pie. And I saw where prescription drugs were only eight percent. I thought that number would be higher.”

Texas focus group participant, white, in his late 50s

Even after discussing the data, participants sometimes had trouble letting go of the idea that pharmaceutical companies are a major driver of overall spending, based on their own experiences of high out-of-pocket spending on pharmaceuticals.

“I’m surprised by the prescription drugs. My sister was diagnosed with Type 1 [diabetes] at 30 years old, and the insulin alone would be my entire yearly salary.”

Wisconsin focus group participant, white, in his mid-30s

“A really big part of the equation is Big Pharma. They are making money hand over fist. They are some of the biggest lobbies out there.”

Texas focus group participant, white, in his late 50s

Participants were initially surprised that the largest share of health care spending goes to hospitals, physicians, and other providers. But as the conversation progressed, they used their own experiences with hospitals and doctors to contextualize the substantial overall spending on providers.

One of the things that pops into my eyes is the 31 percent on hospital care. Anyone who’s ever seen a hospital bill and really looked at it, and when they charge you \$15 for a Tylenol tablet, it’s so out of whack from what reality is.

North Carolina focus group participant, white, in his late 40s

Focus group participants wondered how much of high hospital spending was a result of uninsured people’s being billed at higher rates than insured people. They were curious about how spending is distributed within hospitals and about variation between for-profit and nonprofit hospitals.

Participants often brought up the subject of the salaries of physicians and other medical professionals. They framed the work of medical professionals as a calling or public service worthy of investment and noted the high cost of medical education.

**Health care workers should be paid appropriately. I mean, they're frontline, especially since the pandemic.**

**Wisconsin focus group participant, white, in her early 30s**

Malpractice insurance and lawsuits were only occasionally mentioned as potential causes of higher prices. But participants often complained about physicians scheduling unnecessary visits or otherwise nickeling and diming patients.

**"Doctors always make you want to come back for a follow up even if it's just to read a chart to you. They could have emailed it to you."**

**North Carolina focus group participant, Black, in her mid-20s**

**"They nickel and dime each procedure, you know, they nickel and dime the insurance companies for a lot of money too, so maybe that could be why."**

**Pennsylvania focus group participant, Latina, in her early 30s**

The moderators asked participants to consider a chart from the Health Care Cost Institute (HCCI), showing **cumulative changes in health care spending, utilization, and price** from 2016 to 2020, and one from the American Enterprise Institute, showing changes from 2000 to 2022 in **prices for consumer goods, services, and wages**, including prices for hospitals and other medical care. Participants expressed frustration, bafflement, and indignation at the steep increases in providers' prices, which, they noted, outpace inflation, wages, and prices for other goods and services.

**I truly cannot come up with any kind of justification for why there is such a large gap. Why has that gone up so much more even than housing and food and beverages and average hourly wages? I'm astounded.**

**Wisconsin focus group participant, white, in her early 60s**

Participants often cited corporate greed as they tried to make sense of why prices for hospitals and other providers have been increasing. Several noted that hospitals know patients are a captive audience who do not have choices about whether or not to get care.

**Greed is behind this. It just seems like an arbitrary price hike. That's all I can see.**

**Texas focus group participant, Latino, in his mid-30s**

**Looks like a money grab. I mean, it's ridiculous that the spike from 2016 on is just skyrocketing. It's like everybody wants to make money out of anything.**

**Pennsylvania focus group participant, Latino, in his early 50s**

**"I think the top CEOs are benefiting from the costs. And who gets hurt? The employees, myself, the patients, the workers, the little people. As always."**

**Pennsylvania focus group participant, Black, in her late 50s**

**"They keep increasing the price to see what the market will bear because they know it's a need."**

**North Carolina focus group participant, Black, in her mid-40s**

Inflation and COVID-19 loomed large when participants tried to make sense of why prices for hospital care and other medical services had risen so steeply, even though the moderators reminded participants that the data showed prices increasing well before the pandemic or recent inflation. Participants sometimes theorized that providers increased prices to offset pandemic-related declines in patient volume.

**"The price is going up because the spending and utilization is going down. So they have to compensate for what they were making to continue to make ends meet."**

**Wisconsin focus group participant, white, in his mid-30s**

**Participants initially believed employees pay the bulk of their own insurance premiums, but they understood that both employers and employees are affected by costly premiums.**

The moderators shared a chart showing **employers' and workers' contributions to average health premiums for family coverage** in 2012, 2017, and 2022, adapted from the Kaiser Family Foundation's Employer Health Benefits Survey. Participants generally expected worker contributions to have been higher than employer contributions.

“I was assuming that the companies or employers were a little greedier than they actually are. We're not paying even 50 percent of it.”

Texas focus group participant, white, in his late 50s

“In terms of what I used to pay and what I pay now, I'm actually surprised that that doesn't show more in what we pay.”

Pennsylvania focus group participant, Latina, in her mid-40s

Participants figured that health care costs must cut into profits and might cause companies to raise the prices of their products and services.

“For a small business that's got to be kind of crippling. You're paying over \$16,000 per employee family. If you're a small company or small business, that's got to be pretty difficult for you to stay afloat just with insurance costs.”

Wisconsin focus group participant, white, in his mid-20s

Participants readily provided examples of the impacts of premium costs on both employers and employees. They cited employers hiring fewer workers overall and/or relying more on part-time or contract labor and employees getting smaller annual raises. Some noted employers might feel they have to cover the bulk of premiums to retain talent.

**“Maybe you don’t get a raise. Maybe they don’t increase your pay. Because your benefits are costing more.”**

**North Carolina focus group participant, Black, in her mid-40s**

**“They’ll use the temp labor where they don’t have to pay them as much.”**

**Washington focus group participant, white, in his early 60s**

**“Smaller employers, especially, who don’t have the cash flow might be less inclined to take on new staff.”**

**North Carolina focus group participant, white, in his late 40s**





# Avenues for Further Research and Employer Engagement

This qualitative research raises empirical questions that can be answered with a survey of a representative sample of people covered by employer-based insurance:

- ◆ **Focus group participants were enthusiastic about price regulation and the limiting of mergers.** How widespread are those views among people with employer-based insurance, particularly outside the context of focus groups in which participants had easy-to-understand data and could ask clarifying questions? To what extent do people support other government actions to address high provider prices, such as limits on aggressive debt collection, or more stringent standards for hospitals to merit nonprofit status?
- ◆ **Participants supported employers' advocating for government action to control prices but questioned whether small employers have enough power and large employers have enough incentive to do so.** Survey research could quantify support for employers speaking up and determine what a representative sample of people with employer-based coverage believes stands in the way of their own employers speaking up, including conflicts of interest and lack of capacity.
- ◆ **Participants more often expressed comfort with state than with federal action on prices, but there was not a consensus.** In a representative sample, how would preferences vary for different types of state or federal action? How would preferences vary across political affiliations or other personal characteristics?
- ◆ **This qualitative research uncovered concerns about changes to benefit design, including impacts on access.** How widely held are those concerns? Are they more acute for people who already perceive their choices of providers as limited? Given the concerns that arose in these groups about tradeoffs among access, cost, and quality, a survey could track any changes in Public Agenda's previous finding that most Americans do not believe health care prices are associated with quality.

- ◆ **Participants did not trust insurers to decide which providers are high- or low-quality.** Survey research could explore how people view insurers' trustworthiness to measure various aspects of quality—technical, interpersonal, and administrative—building on questions from Public Agenda's [survey of New York State residents about quality transparency](#). It could also explore trust in other entities to measure quality.
- ◆ **Focus group participants underestimated how much providers' prices contribute to overall health care spending and how much employers contribute to premiums.** How widespread are these misunderstandings? Does a better understanding of spending correlate with more support for government or employer action?
- ◆ **Qualitative findings do not allow for analysis of variation among different groups of beneficiaries.** Survey research could explore differences by and consensus across demographic categories and other personal characteristics, including people's past experiences facing high health care costs.

**Findings from both this qualitative research and a survey could inform efforts to engage employers in taking more active roles in policy and help policymakers make the case for action. For example:**

- ◆ **Strategic communications and engagement could help employers, policymakers, and advocates understand and respond to the views, priorities, and concerns of people with employer-based insurance.** These activities might include facilitated closed-door discussions, presentations, webinars, reports, editorials, and media partnerships. Engagement with nonprofit hospitals or organizations of clinicians who may want to act in good faith toward the people they serve might also be of value.
- ◆ **Confidential in-depth interviews with benefits managers and other employer representatives could help provide a more nuanced understanding of the difficulties they perceive in more actively addressing high provider prices.**
- ◆ **Participants in these focus groups engaged intelligently with information about spending, options for addressing high provider prices, and the tradeoffs among various government actions and benefit designs.** They wanted transparency about how high costs affect their employers and how their employers weigh different benefit designs. Creating and facilitating opportunities for employers to listen to employees grapple with different approaches to addressing prices—outside of the context of benefit enrollment meetings—might help build trust and spur cooperation and action.

# Methodology

Public Agenda conducted five online focus groups in January and February 2023 with 40 residents of Texas, Washington State, Wisconsin, North Carolina, and Pennsylvania. All participants were employed adults ages 18 years and older. All were covered by employer-based health insurance from their own employers, not that of a spouse or parent. A professional focus group facility recruited the participants to Public Agenda's specifications, seeking to include a mixture of men and women and racial and ethnic diversity, based on census benchmarks specific to each state. Potential participants were excluded if they worked in any health-related profession, including being employed by a health care provider, insurer, or pharmaceutical company, or if they worked in human resources, in employee benefits, or for a union.

Public Agenda staff moderated the five focus groups, which were all conducted in English. The moderators informed the participants that ideas they expressed in the groups would be shared publicly and their words quoted. The focus groups lasted two hours, and participants were paid for their time. Within three weeks afterward, Public Agenda staff members conducted in-depth, semi-structured interviews lasting 30 to 40 minutes with twelve of the participants. Both the focus groups and interviews were videorecorded and professionally transcribed. Public Agenda staff developed a coding system and coded the transcripts thematically.

For further detail, please contact [research@publicagenda.org](mailto:research@publicagenda.org).



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