In this month’s Roundup, we highlight some noteworthy articles and reports that discuss 1) state options for provider rate regulation and their potential pitfalls such as regulatory failure and regulatory capture; 2) consolidation trends in the hospital market and pharmaceutical industry; 3) price transparency efforts including compliance with the hospital and insurer transparency rules and the state-federal partnership to implement the No Surprises Act; and 4) drivers of national health spending.

**Provider Rate Regulation**

With the rapid consolidation of health care providers and highly concentrated insurance markets, consumer bargaining power cannot match the power of extant health care monopolies. As Congressional oversight is seemingly unlikely to happen in the near future, state policymakers have the unique opportunity to design a state-specific rate regulation model to exert control over rising health care prices. In Frontiers in Health Services, The Source Executive Editor Katherine L. Gudiksen and Senior Health Policy Researcher Robert B. Murray discuss [Options for States to Constrain Pricing Power of Health Care Provider](#). They suggest that states should assess their health care markets for possible interventions to control costs and prices. Designing these systems will require balancing consumers benefitting from lower prices and the potential for regulatory capture. Specifically, Gudiksen and Murray offered a roadmap of potential options, including: (1) establishing a cost-growth benchmark, (2) creating a public option, (3) capping or establishing a default out-of-network payment rate for health care services, (4) creating affordability standards that authorize the insurance commissioner to reject contracts with excessive rate increases, (5) creating global budgets for hospital-based care, (6) capping excessive prices and/or tiering allowed rate updates, and (7) creating a population-based payment model. Regardless of which option is ultimately chosen, Gudiksen and Murray argue that policymakers should choose a rate regulation
model that fits their state’s specific needs and remain open to adapting it as the market changes.

Robert Murray also published an opinion piece on state rate regulation in The Commonwealth Fund. In *The Pitfalls of Regulating Health Care Prices Are Real but Manageable*, Murray examines past state experiences with rate-setting. He points to New York’s state-based hospital rate-setting system as a remarkable regulatory failure because policymakers set rates and annual rate updates too low, and the overall system became incomprehensively complex. Murray distinguishes this regulatory failure from regulatory capture, which is when regulators prioritize the financial interest of the regulated industry. He asserts, however, that these failures can be avoided. A simpler regulatory system and a long-term perspective with clearly defined and attainable short-term goals, with a preference against frequent large changes to the system, are crucial. Even if regulation results in an imperfect system, Murray argues it may not be worse than a highly consolidated, noncompetitive market. Thus, policymakers that learn from past mistakes and remain committed to regulation should at least attempt some level of regulation.

**Competition/Consolidation**

A recent report from KaufmanHall, *M&A Quarterly Activity Report: Q3 2022* by Anu Singh, et. al. examined mergers and acquisitions between hospitals and health systems and found that activity remained low in the third quarter. While only 10 hospital and health system transactions were announced, the total transacted value of the transactions, which included two mega transactions, is far greater than that of the last few years’ equivalent quarters. This indicates the hospital industry’s continued shift towards fewer, but larger deals. Additionally, Kaufman Hall reported a diversity in the type of acquirer, with one for-profit health system, four academic or university-affiliated entities, one religiously-affiliated entity, and three not-for-profit health systems. The report also predicted the continued trend of portfolio realignment and focused regional growth, as hospitals and health systems focus on building depth and breadth of services within their core markets.

Even with the shifting focus, healthcare consolidation is still occurring and may have
significant effects in the market, including the pharmaceutical space. In *Challenges with Defining Pharmaceutical Markets and Potential Remedies to Screen for Industry Consolidation*, published in the Journal of Health Politics, Policy and Law, Robin Feldman, Brent D. Fulton, Jamie R. Godwin, and Richard M. Scheffler reviewed economic, legal, medical, industry, and government sources to understand consolidation in the unique pharmaceutical market. The authors identified two fundamental problems with pharmaceutical consolidation regulations. First, the current enforcement system relies on a fallacy that products are interchangeable, which discounts differences in therapeutic effects and health plan limitations. Second, conventional regulation assumes a free market which does not factor in the critical price negotiations between drugmakers and pharmacy benefit managers. Given these limitations, the Federal Trade Commission (FTC) has rarely challenged pharmaceutical M&As in the past decade. The decrease in competition has had real implications on patient’s access to drugs, in both physical availability and cost prohibitiveness. With the rise in consolidation in the pharmaceutical industry, the authors emphasize the need to reevaluate the conventional understanding of anticompetitive actions to have proper enforcement of pharmaceutical M&As. Feldman et al. proposed some solutions for regulators to gain control over consolidation in the pharmaceutical industry, including: reexamining the factors for defining market boundaries, viewing mergers involving purely the smallest firms as procompetitive rather than anticompetitive, and increasing congressional funding for the FTC and sister agencies to reevaluate their enforcement guidelines.

**Price Transparency**

Price transparency requirements have changed dramatically within the past two years. As of January 1, 2021, hospitals were required to publish negotiated private-insurer rates, and beginning July 1, 2022, payers were also required to disclose their negotiated rates for all items and services for all providers. Turquoise Health’s *Price Transparency Impact Report* tracked the compliance of the new laws and found that nearly 5,000 or 65% of hospitals and 80 insurance carriers, representing a majority of covered lives in the United States, have published their negotiated rates. The report pointed out that hospitals were slow to comply, while insurers were largely
compliant since the beginning. Additionally, the report predicted that an initial adoption phase of five years is expected to see the true impact of the Hospital Price Transparency Final Rule and Transparency In Coverage Final Rule.

In other federal price transparency efforts, the No Surprises Act requires state and federal governments to work together to enforce surprise billing protections. In No Surprises Act: A Federal-State Partnership to Protect Consumers from Surprise Medical Bills, published by The Commonwealth Fund, Jack Hoadley, Madeline O’Brien, and Kevin Lucia evaluate the current federal-state partnerships to implement the law. Although the Act was signed into law in 2020, most of the provisions only came into effect in 2022. According to the law, states would conduct most of the enforcement action, with the federal government stepping in when a state substantially fails to enforce it. As such, states are given the freedom to choose their own type of enforcement action, even in choosing whether to enforce against providers or against insurers. With this law still in its burgeoning phase, the authors assert that cooperation is key to its success, as the relationship between state and federal roles has not been fully defined. Looking forward, the study suggests that government agencies and researchers should critically analyze whether the state-federal partnership is efficiently operating to ensure the law’s success.

**Healthcare Costs**

On average, the US health care spending is higher than all other comparable high-income nations and that gap further increased during the COVID-19 pandemic. In 2022 Edition – Health Care Costs 101: Federal Spending on COVID-19 Drives Growth, published by California Health Care Foundation, Katherine Wilson noted that in 2020, the US had the largest annual increase in health spending since 2002. Specifically, health spending increased by 9.7% in 2020, doubling the 2019 growth rate of 4.3%. Much of the increase can be attributed to the increased federal spending due to COVID-19 related relief and funding for vaccines and testing. At the same time, out-of-pocket and private insurance spending actually declined by 3.7% and 1.2%, respectively. The report provides further details and a quick reference guide to understand the key data and trends of US health care spending.
That concludes this month's Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way.