catalyst FOR PAYMENT REFORM

Combinations of State-Based Health Care Policies to Constrain Commercial Prices and Rebalance Market Power

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Abstract

As market-based interventions have provided insufficient relief from rising commercial health care costs, states have a unique and pressing opportunity to enact policies that place downward pressure on unit prices and rebalance market power toward health care purchasers and consumers. The geographic, political, and economic diversity across the 50 United States opens possibilities for state governments to shape their own policy agendas; however, states will likely find that a single piece of legislation proves insufficient to effect meaningful relief, and/or will create vulnerabilities that are easily exploited by stakeholders who benefit from the status quo. It is therefore recommended that state legislators consider *suites* or *menus* of policy options to create complementary infrastructure, close loopholes and plan for contingencies. This report leveraged the expertise of health care economists, administrators, legal scholars and other policy experts to identify a universe of high-potential health care policies, which are then organized into scenario-based menus, with the intention of guiding state policymakers and advocates to pathways for a functioning health care marketplace.

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Introduction

In news that will surprise no one, the outlook for the commercial health care market looks depressingly bleak in 2023 and for the next several years to come. Beginning in 2020 with the arrival of COVID-19 on America's shores, health care utilization dropped precipitously – so steeply, in fact, that the federal government and private health plans stepped up to provide funding to keep some hospitals and provider practices afloat. [1,2] This drop in utilization explains why employers and other health care purchasers (henceforth "purchasers") saw their health care costs remain level or even decline over the past three years.[3] Even when inflation hit consumer goods like a sledgehammer in 2022, health care costs remained remarkably stable.[4] But it won't last.

Over the next few years, experts predict that health care costs will spike again. As of August 2022, the projected average premium increase in 2023 will hover at 5.6 percent;[5] while this figure lags behind overall inflation (8.5 percent year over year), this is likely a temporary reprieve, born in part out of the fact that health plans negotiate multi-year contracts with health care providers and cannot react in real time to fluctuations in the consumer price index (CPI). This isn't just speculative; there are clear indicators that health care costs are poised to spike:

- Hospital overhead rose by over 15 percent in 2022, driven by higher labor and supply costs.[6,7,i]
- Despite the drop in utilization in 2020, insurance carriers grossly underestimated service demand in 2021, resulting in $1.3 billion and $1.7 billion losses in the large group and individual markets, respectively – losses that are projected to carry over into premium increases in the years to come.[8]
- Provider markets continue to consolidate, further eroding competition and purchaser market power. Today, 75 percent of hospital markets in the United States are either highly concentrated or very highly concentrated, and the rate of hospital "mega mergers" (under which the smaller of the merging hospitals has an annual revenue >$1 billion) nearly doubled in 2021, along with the rate of physician group mergers and acquisitions.[9,10]

American businesses, their employees, and their families cannot absorb the coming wave of commercial health care cost inflation. Already, nearly one in three households do not have enough savings to pay typical deductibles under employer-based coverage and the rising out of pocket costs experienced by workers for medical care and prescription drugs strains the health and well-being of the US workforce.[11,12] Ultimately, our health care system acts as a weight around the neck of the US economy.

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[i] Some experts believe that this spike in hospital overhead is temporary and will be used as an excuse to further elevate prices unnecessarily.

MARKET-BASED INTERVENTIONS HAVE NOT DELIVERED [ENOUGH]

Historically, purchasers and health plans have tried to overcome failures in commercial health care with market-based interventions. They reasoned that with the right incentives and enough financial "skin in the game," individuals seeking health care would behave like traditional consumers and shop for doctors the way they shop for cars. Consequently, purchasers and insurance carriers attempted to create consumer-like behavior and pursued this goal by providing their health plan members with access to provider price and quality data (to the extent this information is available), and by working to make members sensitive to health care prices through insurance options like high-deductible health plans (HDHPs) or a requirement to pay for a percentage of allowed costs (i.e., co-insurance). It hasn't worked. Studies continuously demonstrate that even when patients have access to data about prices and quality, they rarely consult or act on it;[13] instead of turning plan members into savvy health care consumers, HDHPs simply dissuade people from seeking care, including the preventive and condition management services they need to stay healthy.[14,15]

But what about alternative payment models (APMs)? Did those fail as well? The evidence from the Centers for Medicare and Medicaid Innovation (CMMI) is disappointing: Of the 50 APMs that CMMI developed following the passage of The Affordable Care Act, only six generated substantial net savings after factoring in the cost of incentive or upfront payments.[16] With time, there is hope that refining APM programs by making them mandatory and including downside risk will produce consistently stronger outcomes. But APMs operate on the theory that paying providers differently will change how they deliver care and result in greater efficiency, better care coordination, and reduced waste. That may be correct, but it's prices, not utilization that is driving about two thirds of health care cost inflation for commercial payers.[17] APMs are a necessary component of health care reform, but by no means a panacea.

THE CASE FOR STATE GOVERNMENT INTERVENTION

What we see before us is an uneven playing field, about to get rockier, and the only balancing force that may be powerful enough to countermand this trend is the government. The federal government issued new laws and regulations this year such as the No Surprises Act, the Hospital Price Transparency Rule, and the Health Plan Price Transparency Rule, which (if hospitals and health plans comply) could start to shift the competitive landscape – or at least provide policymakers and other stakeholders with better data for decision making.[18,19,20] But states also have a unique and profound role to play in shaping health care policy. They can tailor their policy agendas to the specific needs, conditions, and mores of their constituents; they can launch smaller-scale experiments that would be impractical or impossible to pass nationally; and they can use their own purchasing power to command lower prices, new payment models, and higher standards of care. Innovation springs from state laboratories across the country, from the first reference-based pricing program in Montana, to the first full-scale bundled payment program from Tenncare (Tennessee Medicaid), to the health care coverage model that inspired the Affordable Care Act out of Massachusetts.[21,22,23]

THE CASE FOR POLICY "MENUS"

An adage, often attributed to W. Edward Deming, says that "every system is perfectly designed to get the results it gets." As such, the fact that health care costs in the U.S. rise faster than the rate of inflation year after year without any commensurate increase in quality or value speaks to fundamental flaws in system design. Fixing a $4 trillion industry that comprises nearly 20 percent of U.S. GDP doesn't come easy and likely cannot be solved through a single piece of legislation.

Catalyst for Payment Reform (CPR), with support from Arnold Ventures, created this report to help more states carve their unique paths to place downward pressure on commercial health care prices. This report is certainly not the first to advise states on health care policy, but offers a unique contribution to the space based on the following premises:

- Of the myriad approaches states might take to address unsustainable growth in commercial health care prices, some policies have proven to be more effective than others.
- With that said, not every policy is right for every state: states have to operate under diverse conditions, with contingencies that include – but are not limited to – the provider composition of the health care market, how well the health care market functions, the state's openness to government intervention, and what infrastructure a state has in place to implement and administer market interventions.
- A critical short-coming of policy-craft is a tendency to pass one legislative initiative at a time, then attempt to course correct for loopholes and externalities as they appear. A more prudent (but perhaps politically challenging) approach is to look at a suite of policies in tandem, which reinforce each other toward an aligned set of priorities.
- There are new and creative ways to address commercial health care costs that deserve exploration.

With these tenets in mind, CPR leveraged the insight and acumen of some of the nation's foremost luminaries in health economics, health care policy, and state government administration to create a series of ***policy menus***: constellations of policy options geared toward specific goals, with indicators to connote prerequisite measures, next steps, and whether the policy is appropriate for states with a lesser appetite for government intervention.

Methodology

Creating the policy menus required both primary and secondary research. CPR conducted a literature review of academic and trade journals seeking evidence about the impact of the policies we had identified, whether they proved effective or ineffective, and whether they resulted in any externalities, loopholes or other unintended consequences. However, understanding the "juice-to-squeeze" ratio of policy options (i.e., effort vs. effect), how policies fit together, and what new policy options are on the horizon required direct input from experts. CPR convened an advisory committee with expertise in three domains of health policy: transparency, competition, and regulation. With the support and expertise of this advisory committee, CPR sought to answer the following three questions:

1. Of the thousands of state laws currently in existence that purport to control commercial health care prices, which should we consider in scope for our project and which policies are most impactful under what circumstances?
2. What new policies – either those that have shown promise in early pilots or are entirely sui generis – should states consider?
3. How do policies fit together? Which have prerequisites, and which should only be tried if all else fails? What are likely scenarios, based on common use cases or constraints, for which we should create policy menus?

We address these topics in turn below. Note that a complete methodology, including a list of the members of CPR's advisory committee, can be found in appendices 1-2.

WHAT CATEGORIES ARE IN SCOPE, AND WHICH POLICIES ARE MOST IMPACTFUL?

Given the wide array of approaches states can pursue to address health care prices, CPR's first step was to define the ocean we wanted to boil. Policy areas that CPR determined to be out of scope included:

a. *Pharmaceutical Prices:* Although pharmacy costs continue to accelerate and absorb a larger share of total health care expenditures, the inflation factors driving drug prices and pharmacy benefit managers' (PBM) spend differ notably from the economic drivers of the care delivery system, and moreover, may be better suited for federal policy.
b. *Single Payer Health Care:* Single payer health care necessitates a fundamental and comprehensive reworking of the current health care system. This is not to say that single payer health care has no place in state policy discussion, but rather that reform on this scale will render nearly all other policy pathways irrelevant.
c. *Care Delivery*: Because this report focuses on commercial markets, where prices (not utilization) drive nearly two thirds of health care cost inflation, CPR excluded policies that focus exclusively on improving the quality and efficiency of care delivery. While these approaches may ultimately have an impact on total health care spend, their impact on health care prices is indirect, at best.
d. *Federal Policy:* Lastly, because of the project's focus on states, CPR excluded policies that apply exclusively to the federal government.

Beyond the scoping exercise, which eliminated policies based on applicability, CPR and the advisory committee also identified a set of policies to exclude from this analysis based on judgments of their utility and impact. These policies, and the rationale for their exclusion, are documented in Table 1:

Table 1 - Excluded Policies

Excluded Policy	Exclusion Rationale
Supplemental Surprise Billing Legislation	***Unnecessary*** • Federal law already offers strong protection.[ii] • State laws would not apply to ERISA plans, which leads to bi-furcated targets and resolution processes.
Any Willing Provider and Network Adequacy Laws	***Harmful (mostly)*** • Impedes competition and erodes purchaser market power.
Certificate of Need (CON), Certificate of Authority (COA), and Certificate of Public Advantage (COPA)	***Too vulnerable to misuse*** • While these policies have the potential to *promote* competition, for the most part, they have failed in practice.
Right to Shop, Telehealth Parity, and Scope of practice	***Low impact*** • Low evidence that patients are able/willing to leverage data to shop for providers. • Little evidence that telehealth and scope of practice will introduce meaningful competition.

WHAT NEW POLICIES SHOULD STATES CONSIDER?

In addition to evaluating and cataloguing existing policies, the advisory committee also proposed and explored new and untested policy ideas. In a “shark tank” exercise, committee members each presented their idea for a new policy, explained how it could correct market failures and/or put downward pressure on health care prices, described the resources or supplemental policies needed for success, and explored the risks/externalities the policy might pose.

[ii] Even though the Federal No Surprises Act is limited to select services and questions remain regarding the effectiveness and implementation of the arbitration model, supplemental legislation is considered unnecessary due to the strong protections already offered by this Federal law.

HOW CAN WE ALLOCATE POLICIES INTO USE-CASE MENUS, ORGANIZED AROUND A SET OF OBJECTIVES A STATE MIGHT PURSUE OR CONSTRAINTS IT MAY FACE?

Having both defined and supplemented a universe of relevant, high-potential policy approaches, CPR's next step was to organize this (smaller) universe into some kind of schema or framework. There are thousands of ways to categorize state policies that address commercial health care prices; CPR tried every single one.[iii] Ultimately, we landed on allocating policies according to the *lever of power* that state governments can use to rebalance health care market power, which aligned well the use-cases we identified for the state menus.

1. **Ban or punish bad behavior:** Examples include banning anticompetitive contracting practices; taxing excessive provider prices or wealth; or constraining the behavior of newly consolidated entities.
2. **Shore up competition and/or protect the market from further erosion:** Examples include expanding antitrust law to prevent mergers and other acquisitive activity; introducing a new supply of providers or health plans; or requiring health plans to guide plan members toward higher-value providers.
3. **Directly regulate provider prices and/or insurance premiums:** Examples include placing caps on provider prices, caps on insurance rate increases, or setting global revenue targets for hospitals and health systems.
4. **Build regulatory infrastructure*:*** Examples include creating a repository of claims data, hospital financial data, and creating government infrastructure to monitor market trends and recommend policy interventions.

The curated list of policy options according to the category of state government power is in Figure 1 below. Detailed descriptions of each of these policies, which include evidence of impact and key considerations for policymakers, are provided in the embedded file below.

[iii] A complete description and inventory of the frameworks CPR tried (and ultimately discarded) is included in the appendix for those who are interested.

Figure 1: Universe of Policy Options by Lever of Government Power

BAN (PUNISH) BAD BEHAVIOR	PREVENT FURTHER EROSION OF COMPETITION	REGULATE COSTS /PRICES	BUILD INFRASTRUCTURE
Ban anti-competitive contracting	Horizontal Merger Notification/Approval	All-payer Rate setting	All-Payer Claims Database
Prohibit Hospitals from Collecting Medical Debt if Non-Compliant with Federal Hospital Price Transparency Rule	Expanded Powers of the office of the Attorney General to Approve Acquisitive Activity and Pursue Anticompetitive Behavior	Global Budgets	Health Policy Commission
Prohibit Unwarranted Facility Fees that result from Vertical Consolidation	Review of Cross-Market Mergers	Cap Commercial Prices for State Employee Health Plans	Cost Growth Benchmarks or Total Cost of Care Targets
Tax Excessive Hospital Prices/Wealth OR Revoke State Not-for-Profit Tax Exemption	Public Option	Cap Commercial Provider Prices & Rate Increases	Database of Hospital Audited Financial Statements
	Require Large Employers to Offer Narrow Network Option	Cap Out-of-Network Prices	
		DOI Commercial Insurance Rate Regulation and Affordability Standards	

Link to Policy Descriptions

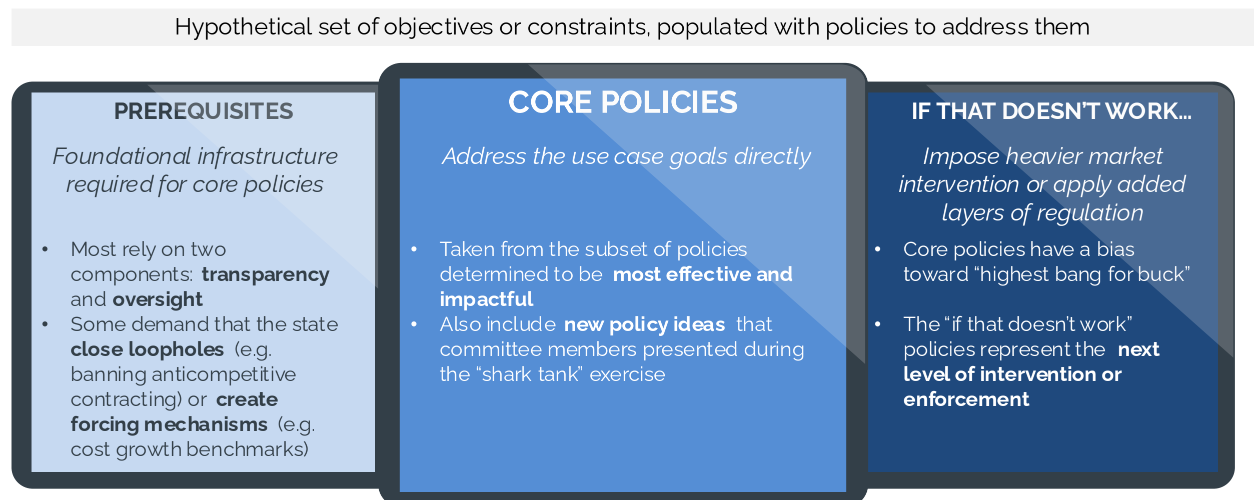
Policy Descriptions
Embedded Documer

Scenario-Based Policy Menus

I. Organizational Framework

With approximately 20 unique policy options for placing downward pressure on commercial health care prices, the next step was to allocate these policies into use-case menus, organized around a set of objectives a state might pursue or constraints it may face. The menus are organized into three parts: prerequisites, core policies and "if that doesn't work" policies, as illustrated in Figure 2.

Figure 2: Policy Menu Structure

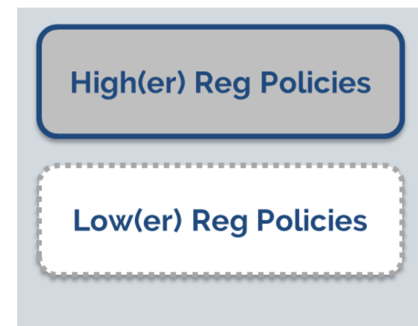


ADDITIONAL POLICY MENU CONSTRUCTS:

1. **Annotation for high-regulation vs. low-regulation policies**

   As noted, some policies require lower government intervention and may therefore be more palatable to traditionally low-regulation states. There are few easy fixes in state policy, but some policies require less oversight, and/or are more likely to appeal to low-regulation states. These policies are indicated with lighter shading and a dotted outline, as shown in Figure 3.

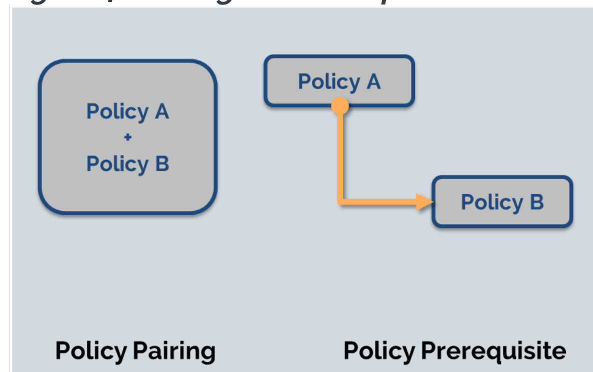
Figure 3: High-Regulation vs. Low-Regulation Policies



2. **Infrastructure "Lite"**
   In limited circumstances, a state may be able to implement core policies while relying on pared back infrastructure. For example, pertaining to an All-Payer Claims Database (APCD) an "APCD Lite" might leverage existing sources of quality data, such as the Sage Transparency web-based tool, the RAND Hospital Price Transparency Study, or other existing sources of hospital pricing data. In another example pertaining to a Health Policy Commission (HPC), a "HPC Lite," might study the market to observe trends but lack powers of enforcement. CPR and its advisors do not necessarily endorse the pared-down versions of infrastructure policy; however, it is important to acknowledge and build pathways for states who may otherwise lack the financial resources or political capital required to support full-fledged versions of these policies.

3. **Policy Pairings vs. Prerequisites**
   Some policies work in symbiosis, whereby one policy closes a loophole or prevents an externality of the other. For example, pairing provider price caps with caps on provider rate increases ensures that prices do not automatically float up to the maximum. In the menus, these symbiotic policies are shown as X + Y. Separately, there are policies that have sequential linkages (i.e., prerequisites) such that Policy B is not possible without Policy A. These policies are attached by an arrow, or a dotted arrow if the linkage is weaker. The two methods of displaying policy connections are illustrated in Figure 4.

Figure 4: Pairings vs. Prerequisites



With these constructs, CPR created five use-cases menus of policy options. They are by no means an exhaustive list of the scenarios and objectives states may face as they consider their health policy strategies; however, they do cover all the policies within our curated universe, acknowledge a diverse set of objectives, and illustrate how policies complement each other such that policymakers can easily mix and match according to their unique circumstances.

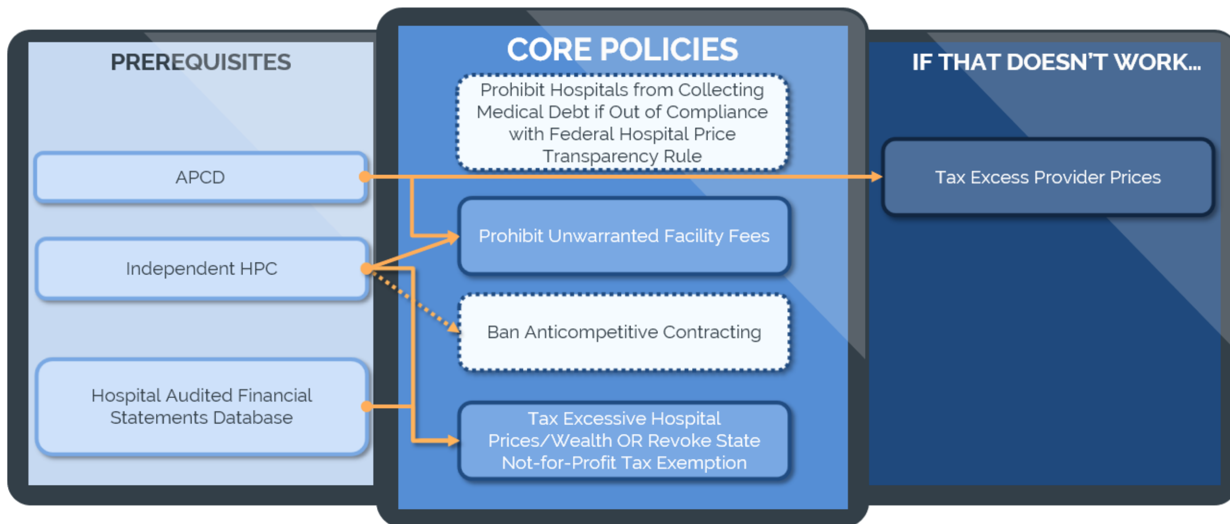
The policy menus speak to the following scenarios:

As a policymaker, I want to…

1. Defang or punish the most egregious bad actors.
2. Shore up the market against consolidation and rising prices.
3. Empower existing "balancers" of market power (i.e., employers and carriers).
4. Regulate provider prices.
5. Pick the lowest hanging fruit.

II. Menu Descriptions

MENU #1: Defang or Punish the Most Egregious Bad Actors



WHY THIS MENU?

This menu is designed for policymakers in a market with significant failures of competition, and where powerful actors (mostly providers, but possibly health plans) abuse their market position to further skew the playing field. It comprises policies designed to prevent would-be market monopolists from engaging in anticompetitive behavior and penalizes those who abuse their market power.

CORE POLICIES AND PREREQUISITES:

The policies in this menu fall into two categories: preventing health care actors from exercising anticompetitive behavior, and exacting appropriate penalties for doing so.

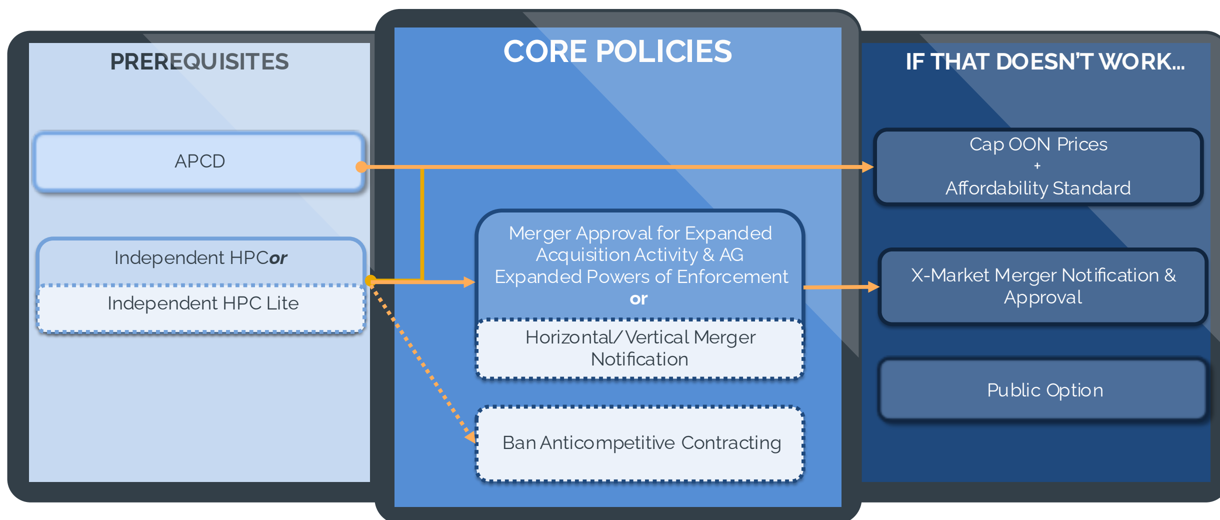
- Banning bad behavior:
    - To prevent abuses of market power, states can start by explicitly prohibiting anticompetitive contracting practices; they can also intervene further downstream by banning unwarranted facility fees from health systems that have acquired physician practices.
    - It's possible (although not recommended) to ban anticompetitive contracting without active enforcement, relying on signal without follow through. Banning unwarranted facility fees, however, requires robust transparency – possibly beyond what can be extracted through an APCD – and oversight to analyze the data and identify unwarranted fees.
- Punishing bad behavior:
    - There are multiple ways that states can penalize health care entities that abuse their market power; the policies in this menu were selected based on operational feasibility and the tightness of the relationship between the undesirable behavior and its consequences:

- Prohibit hospitals from collecting medical debt if out of compliance with Hospital Price Transparency rule: modeled after HB-22-1285 in Colorado, this policy prohibits hospitals from using debt collectors, filing negative credit reports, or threatening to bring lawsuits against patients, if the hospital is out of compliance with the federal Hospital Price Transparency rule. Given the enforcement mechanism is through individual patient lawsuits, no enforcement is required on the part of the state.
- Tax hospitals' excess wealth or remove their non-profit status: This policy first requires states to track hospital wealth through a database of audited financial statements. By identifying facilities that have accumulated excessive wealth (to be defined by the state), the state can remediate by removing the facility's non-profit status to justify exacting a tax on the hospital's wealth. In addition to the database, this policy requires administrative resources to analyze data and identify outliers.

IF THAT DOESN'T WORK...

If none of these policies achieves its desired effect, and powerful actors continue to engage in anticompetitive behavior, states could take the "punish bad behavior" strategy one step further and tax excessive provider prices. This policy is coded as an "if all else fails" because of the inherent complexity in design and enforcement.

MENU #2: Shore Up Market Against Consolidation and Rising Prices



WHY THIS MENU?

This menu is designed for policymakers who oversee a market that still retains some functional competition, but is at considerable risk of horizontal, vertical, or cross-market consolidation. The policies in this menu are intended to empower the state's Attorney General (AG) to monitor or approve acquisitive health care activity and enforce bans on anticompetitive behavior.

CORE POLICIES AND PREREQUISITES:

- The core policies in this menu focus on expanding the powers of the state's AG, by broadening the scope of acquisitive activity that comes under the AG's purview, and by granting the office additional remedial powers to fine or sue health systems that abuse market power. Although responsibility for preserving market competition can reside exclusively within the AG's office, it may be beneficial to coordinate efforts with an independent HPC, which may have resources better suited to analyzing the presumptive impact of merger activities on the health of the health care market.
- For low-regulation markets, granting the AG's office this broad authority may be infeasible; however, at a minimum, a low-regulation state could pass laws requiring horizontal and vertical notification to the AG's office. Although a notification policy does nothing to block a merger from moving forward, it at least removes any excuse of ignorance on the part of the AG's office.
- As a corollary, it also makes sense for the state to pass laws that ban anticompetitive contracting practices. In a high-regulation state, the AG's office would be responsible for enforcing these prohibitions; in a low-regulation state, the policies might lack an enforcement mechanism, but at minimum signal that anticompetitive contracting is illegal.

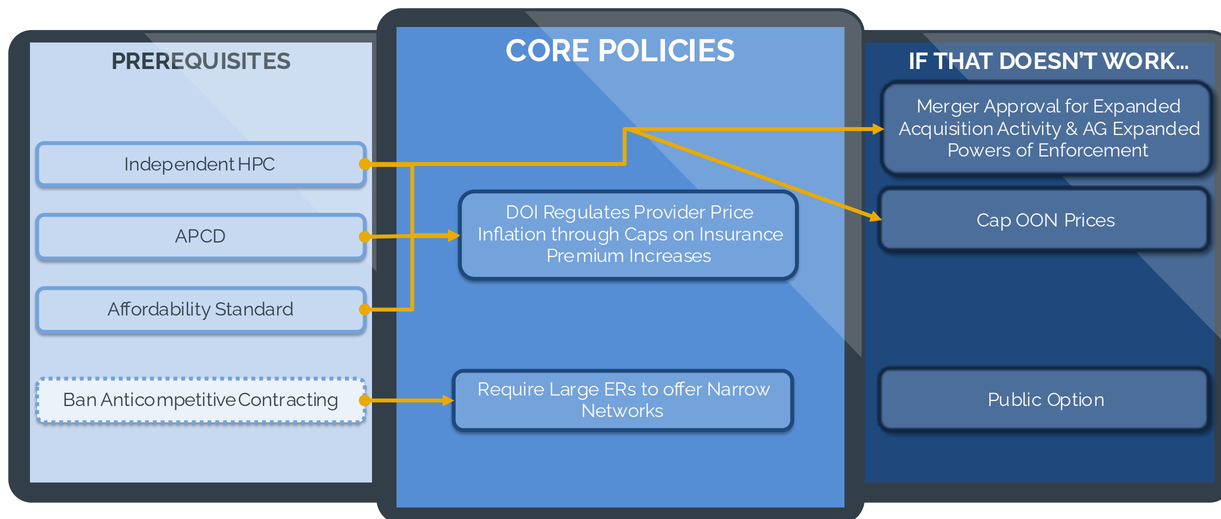
IF THAT DOESN'T WORK…

If a state wants to take additional steps to shore up existing market competition, capping out-of-network prices to a Medicare benchmark strengthens negotiating leverage for health plans and purchasers, and may remove the incentive for provider mergers – to some degree. The state will want to couple this policy with some form of insurance premium affordability standard to ensure that savings from lower provider prices are passed along to purchasers and health care consumers.

- Transparency and enforcement mechanisms are necessary to establish and enforce out-of-network price caps. Although a state may not need a full-bore APCD to set out-of-network price caps, it will certainly need access to state-wide data to measure impact on prices, utilization and quality, and will require oversight through an independent HPC to calibrate its benchmarks and ratchet them up or down as the market responds.
- Another additional step for states is to collaborate across state lines to monitor and approve cross-market mergers. This strategy will require significant coordination among states, and a reckoning with complex interstate commerce laws – which is why it is placed outside the core policy set.
- Finally, if expanded antitrust enforcement fails to provide a sufficient retaining wall against the erosion of competition, or if prices continue to rise, states could consider introducing a public option health plan. While a public option does not improve provider competition, it does increase *health plan* competition, and the lower prices the state negotiates with providers has the potential to spillover to other commercial payers.[iv]

[iv] The reason that a public option has greater potential to place downward pressure on *all* commercial prices than a state employee health plan is because employers and other health care purchasers can opt into the public option plan but cannot opt into the state's employee health plan.

MENU #3: Empower Existing "Balancers" of Market Power (i.e., Employers and Carriers)



WHY THIS MENU?

Discourse on "rebalancing market power" tends to focus on constraining the power of provider entities; but on the flip side, states can also rebalance the market by strengthening the leverage of health plans and purchasers. The policies in this menu therefore focus on compelling carriers to return to the negotiating table with providers who demand exorbitant rate increases, and/or compelling purchasers to offer competitive network products that strengthen the market position of higher-value health systems.

CORE POLICIES AND PREREQUISITES:

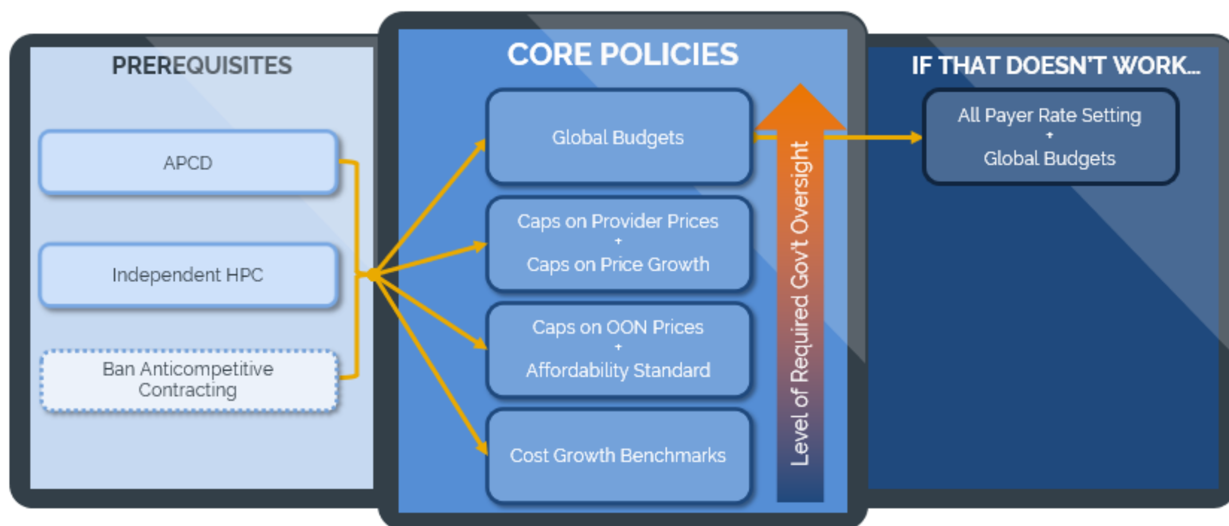
- To empower (or compel) carriers toward hardline provider negotiations, states can pursue a strategy similar to Rhode Island's, under which the Department of Insurance (DOI) is granted authority to approve the "inflation factors" built into each carrier's rate. This policy is attached to three prerequisites:
    - Some degree of transparency into market prices – preferably through an APCD so that states can access both point-in-time comparisons and year-over-year cost trend.
    - Affordability standard, to serve as a forcing mechanism that justifies the state's regulation of inflation factors.
    - Independent HPC or "HPC Lite" to analyze health care prices and make recommendations to the DOI.
- To empower (or compel) purchasers toward rebalancing market power, states can mandate that large purchasers offer a high-quality, narrow network product as one of its offerings to plan members, e.g., alongside a broad PPO. This approach also requires states to pass anticompetitive contracting bans. Without these bans, carriers may be unable to exclude high-cost providers from their high-performance network products.

IF THAT DOESN'T WORK…

If these efforts fail, states can take a heavier-handed approach to rebalancing market power and introducing competition. This can take shape through any of the following:

- A public option health plan that the state administers, which offers lower premiums than the commercial payers.
- Expanding the AG's merger approval authority to slow consolidation activity and pursue providers who engage in anticompetitive behavior.
- Capping out-of-network prices to blunt the financial rewards for providers who opt out of carrier networks.

MENU #4: Regulate Provider Prices



WHY THIS MENU?

For some states, the best and most viable path to improving health care affordability may be the direct route: regulating provider prices. This menu contains a set of policy options for price regulation, organized according to the degree of state oversight, resources and sophistication required to administer them.

CORE POLICIES AND PREREQUISITES:

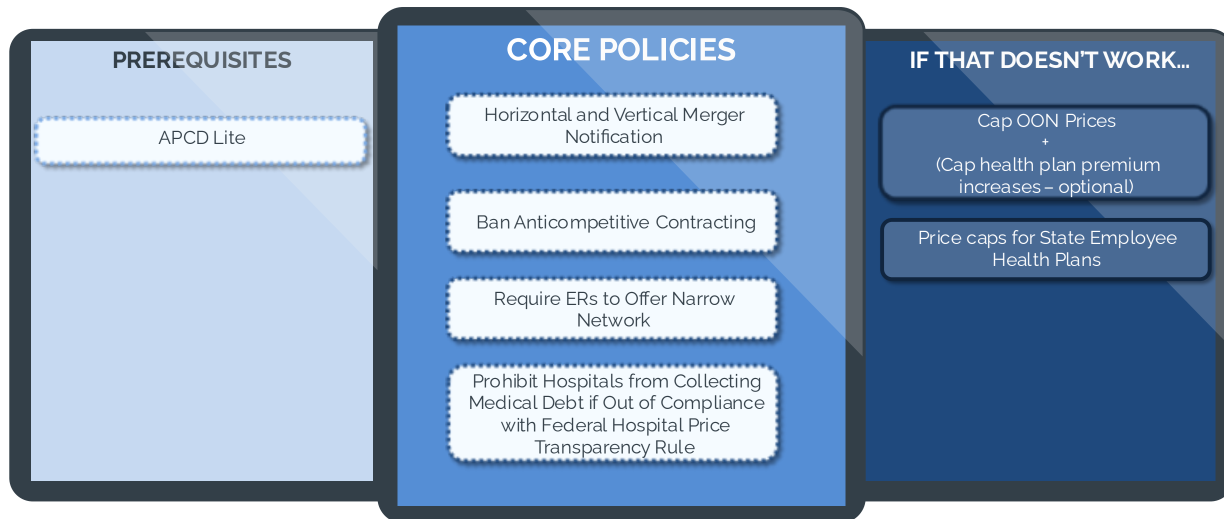
- Every approach to regulating provider prices that is profiled in this menu requires four prerequisites:
    1. Transparency, decidedly through an APCD and potentially supplemented with additional data sources.
    2. Oversight and administration through an independent HPC.
    3. Cost growth benchmarks as a forcing mechanism for the state to take further action if current regulatory strategies fail to constrain total expenditure.
    4. A ban on anticompetitive contracting practices, to prevent providers from making up lost revenue by unfair capture of market share.

- The core policies in this menu are organized from bottom to top according to the complexity and resources required to enact and administer each approach:
  - Lower-level complexity: cap out-of-network prices and cap health plan rate increases. Capping out-of-network prices can have spillover effects on in-network rates because the caps diminish financial returns for providers to opt out of carrier networks. It is important to couple this policy with caps on health plan rate increases to ensure that health plans pass savings along to their customers.
  - Mid-level complexity: Public Option. This menu capitalizes on the regulatory impacts of a public option, under which the state can cap provider prices and compel providers to participate in its network.
  - Higher-level complexity: Cap commercial provider prices. There are several options for capping commercial provider prices: either capping at the service level using multiples of Medicare or observed commercial prices, or alternatively, states may take an actuarial approach and cap provider prices based on units of service. These caps should also be paired with caps on price growth such that lower-priced providers do not immediately rise to the cap. This policy exerts a greater degree of state control over provider prices than the two strategies that precede it, and consequently requires considerable effort and resources to enforce and sustain it.
  - Highest-level complexity: global budgets. Global budgets require the state to set revenue caps for hospitals. When de-coupled from a universal hospital fee schedule (all-payer rate setting) this requires the state to set targets for each individual hospital using historic trend data. This policy has never been attempted state-wide without the state's full regulation of provider prices across all payers, but that does not mean that it's impossible (perhaps just very difficult).

IF THAT DOESN'T WORK…

The most comprehensive approach a state can take to regulate provider prices is to follow Maryland's footsteps and establish all-payer rate setting. Maryland policymakers found, however, that setting all-payer rates still leaves room for providers to make up for lost revenue by increasing their patient volume. For this reason, this policy will be most effective if coupled with hospital global budgets, effectively capitating spending state-wide. This approach to regulating costs effectively amounts to a state takeover of the marketplace and requires a federal waiver and constant monitoring to ensure its success.

MENU #5: Pick the Low-Hanging Fruit



WHY THIS MENU?

Some states may lack the resources to pursue complex policy interventions; others may operate in political climates inhospitable to government intervention; a small few may have health care markets that function reasonably well and don't require major fixes. This menu is designed for states who are searching for low-hanging fruit and easy(er) wins.

CORE POLICIES AND PREREQUISITES:

The core policies in this menu were selected because they require minimal infrastructure and oversight to administer:

- Horizontal and vertical merger notification: although a notification policy does nothing to block a merger from moving forward, it provides transparency into acquisitive health care activity, and could serve as a first step toward granting the AG's office the power to approve health care mergers.
- Bans on anticompetitive contracting: even in states that resist government intervention, banning excesses and abuses of power is unlikely to cause objections of overreach, and such bans signal to providers that anticompetitive behavior will not be tolerated.
- Requiring employers to offer a narrow network: of the three core policies, this policy might be the hardest sell for low-regulation states because it may draw resistance from the employer community. That said, from an administrative perspective, requiring employers to offer a narrow network imposes minimal government intervention in regulating health care markets and requires less administrative effort than price regulation or heightened scrutiny of mergers.
- Prohibit hospitals from collecting medical debt if out of compliance with federal Hospital Price Transparency rule: Leaving aside the political controversy that a law like this may trigger, the policy itself deserves to live in the menu of low-hanging fruit given the negligible amount of administrative resources it requires. After all, as proposed, this law empowers individual citizens to sue noncompliant hospitals; it

therefore relieves the state from an obligation to pursue the hospitals and absolves it from bringing or defending litigation.

- APCD Lite: Although none of these policies explicitly requires a source of transparency data, taking advantage of the available price transparency resources is something every state should consider, if solely for the purpose of understanding prices and trends within the marketplace.

IF THAT DOESN'T WORK...

The core policies in this menu, although relatively easy to administer, may not make a profound impact on health care affordability. As such, the next step that low-regulation states can pursue is to:

- Take a slightly more aggressive stance by capping out-of-network rates, which requires a much lighter touch than regulating commercial prices across the board.
- Or revamp the market on a small scale by capping commercial prices for the state employee health plan, which will not improve affordability for all constituents, but will at minimum offer cost-savings to the state's budget.

Concluding Thoughts

Every industry has its own idiosyncrasies, but it's fair to say that the health care system in the United States ranks at the top for its complexity, size, scale, and (quite literally) life-and-death implications. Beyond the fact that health care comprises 20 percent of the nation's GDP and employs 14 percent of American workers, every one of us at some point in our lives will use health care services. As a society, we cannot allow healthcare markets to fail. Yet, whether the correct term is "ailing" versus "failing" it's clear that health care markets have been, continue to be, and are projected to remain in dire straits.

Realizing a vision of affordable, high-quality health care that is accessible to all commercially insured Americans will take a village. It's clear that market-based fixes like APMs and efforts to instill consumerism among health plan participants have fallen short of their goals. As such, one can argue that there is not just a role for government but an obligation for it to step in to help rebalance and reset commercial health care markets. While the federal government plays an important role in health care policy, it lacks the specificity and flexibility to tailor policy to the sui generis nature of all fifty states. The diverse political climates, geographies and economies across the states put states in a better position to design policy agendas that are specific to the norms and needs of their constituents. And finally, it should be apparent that no single policy is sufficient to deliver meaningful results. Curbing health care price inflation and rebalancing market power require clusters or constellations of policies that work in tandem to supply infrastructure and close loopholes.

The scenario-based policy "menus" described in this report provide states with options to address common sources of market failures; they identify the prerequisite policies that build infrastructure and supply data; and they offer an array of alternative "next steps" if the core policies do not achieve their intended effects, or if the state wishes to take a heavier hand in regulating the market. It is our intention to provide new perspectives on the landscape of health care policy and support informed decision-making and strategy development. There are no easy answers, no solutions without trade-offs, and unfortunately no guarantees these policies can pass through legislatures and deliver results. But lessons from states who have successfully implemented these strategies combined with the advice and wisdom of experts who supported and informed this work lay the groundwork for reform. Public policy rarely produces a panacea, but when private markets fail, policy can offer corrective measures to re-level the playing field. In the eloquent words of Dr. Atul Gawande: "Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."

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