The Case for Rate Regulation of Hospital Prices

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Erin C. Fuse Brown, *Resurrecting Healthcare Rate Regulation*, 67 **Hastings L. J.** (forthcoming, 2015), available at SSRN.

With health spending in the U.S. outpacing both general inflation and spending by other developed nations, policymakers have targeted their attention on a primary culprit for our excess costs – high health care prices. Economists and other experts have offered a range of policy solutions to discipline health care prices in the United States. Using hospital prices as her case study, Fuse Brown provides a comprehensive analysis of these policies. In doing so, she guides the reader to two important conclusions: first, that there is no single solution that addresses the full range of market failures that cause high hospital prices and that a combination of approaches is therefore necessary; and second, that the package of solutions must include direct rate regulation of hospital prices for the most health care markets. This article builds on Fuse Brown's earlier article, Irrational Hospital Pricing, 14 **Hous. J. Health & Pol'y** 11 (2014), which explains the harms caused by the current hospital pricing system.

Fuse Brown's new article begins with a clear and succinct discussion of the market failures that cause high hospital prices. Most importantly, she explains how the growing concentration of hospital markets has reduced competition, removing a necessary price constraint. The article also discusses the principal-agent problems that plague health care, information asymmetries that leave the patient-consumer unable to make informed purchasing choices, and moral hazard created by reliance on third-party insurance to finance health care. Fuse Brown then explains the externalities that a dysfunctional hospital pricing system imposes on the uninsured and underinsured, such as harsh debt collection practices and personal bankruptcy.

Part II then systematically evaluates the policy solutions for disciplining hospital pricing, assessing the extent to which each one addresses the various market failures identified in Part I. Specifically, Fuse Brown evaluates the merits of market solutions, antitrust enforcement, payment and delivery reforms, consumer protections, and direct rate regulation. This discussion is what sets Fuse Brown's article apart from other scholarship on excessive health care prices. Whereas other scholars have considered only one or two policy approaches in isolation, Fuse Brown allows us to compare their relative strengths and shortcomings side-by-side. In presenting a comprehensive, side-by-side analysis of the different policies, Fuse Brown allows the reader to see the big story—that rate regulation is the only policy prescription capable of addressing the growing problem of highly concentrated markets, and that rate regulation must be paired with payment and delivery reforms (e.g., bundled payments, shared savings for accountable care organizations) that address the principal-agent problems driving overutilization.

Fuse Brown's discussion of the shortcomings of market solutions and antitrust enforcement is particularly informative. The article explains that the market solutions popular among policymakers—pricing transparency, consumer-directed health care, reference pricing, and tiered and narrow networks—will not work in concentrated markets where there is little choice or competition among providers. In these markets, patients simply cannot shop around or substitute lower-cost or higher-value providers, even if given pricing information or financial incentives to be more cost-conscious consumers. Unfortunately, society's weapon for addressing market concentration—antitrust enforcement—is an imperfect solution. Building on the work of Tim Greaney, Fuse Brown explains that

antitrust laws tolerate extant monopolies, in particular, providers that have lawfully gained their existing market power such as “must-have” hospitals providing unique services, or as the sole hospital in geographic areas that cannot support multiple hospitals. Consequently, antitrust enforcement cannot reach many, perhaps most, of the already highly concentrated provider markets. Moreover, the antitrust agencies have been hesitant to block the current trend of provider consolidation given the potential benefits of integration (e.g., better care coordination, improved quality).

The article also provides an overview of the different models of direct rate regulation – all-payer rate setting, caps on negotiated rates, and single-payer. That discussion briefly notes the challenges of rate regulation generally, including its inherent complexity, the risk of agency capture, and bureaucratic inefficiencies. While Fuse Brown’s article does not argue for a particular form of direct rate regulation or suggest how to overcome these challenges, I anticipate that her future scholarship will do exactly that. I look forward to hearing her specific policy recommendations.

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