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The Impact of Hospital Markets on Health Care Affordability for Texans

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Testimony of:
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Select Committee on Health Care Affordability
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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.

Chair Frank, Vice Chair Rose, and distinguished members of the Select Committee on Health Care Affordability, thank you for the opportunity to testify today. My name is Christopher Whaley. I am an associate professor of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on how to reduce health care costs, the role of price transparency, and the impacts of evolving health care markets. The remarks I deliver today are in my personal capacity as an expert on U.S. health care markets and are informed by several recent studies from my colleagues and me examining hospitals, market consolidation, and price growth.

My remarks today highlight both the impacts of high and rising health care prices, as well as how a wide range of state-led innovations attempt to improve U.S. health care affordability. As other states have learned, improving health care affordability requires a level playing field for patients, as well as use of transparent pricing and market data.

Hospital Price Growth and Consolidation

I first want to acknowledge the importance of access to high-quality and affordable health care for all Texans. Regardless of geographic region or income, access to hospital care is critical. Hospitals deliver life-saving care that makes us all healthier and improves our well-being. Hospitals are also a key source of employment. In many localities, the local hospital is the largest employer. The hospital sector is among the largest in the US economy. Hospital care accounts for over $1.5 trillion in annual spending, approximately 31% of health care spending, and alone 5.2% of the U.S. GDP.[2]

Yet, growth in hospital prices threatens the affordability of health care in the United States. Over the last two decades, commercial prices for hospital care have increased rapidly. According to an analysis conducted by the American Enterprise Institute, prices for hospital care have increased faster than prices in any other sector of the U.S. economy.[3] Since 2000, hospital prices have increased by over 220%, nearly three times overall inflation growth. Hospital price growth outpaces price growth in high-technology areas, such as general medical services, consumer electronics, and computer software.

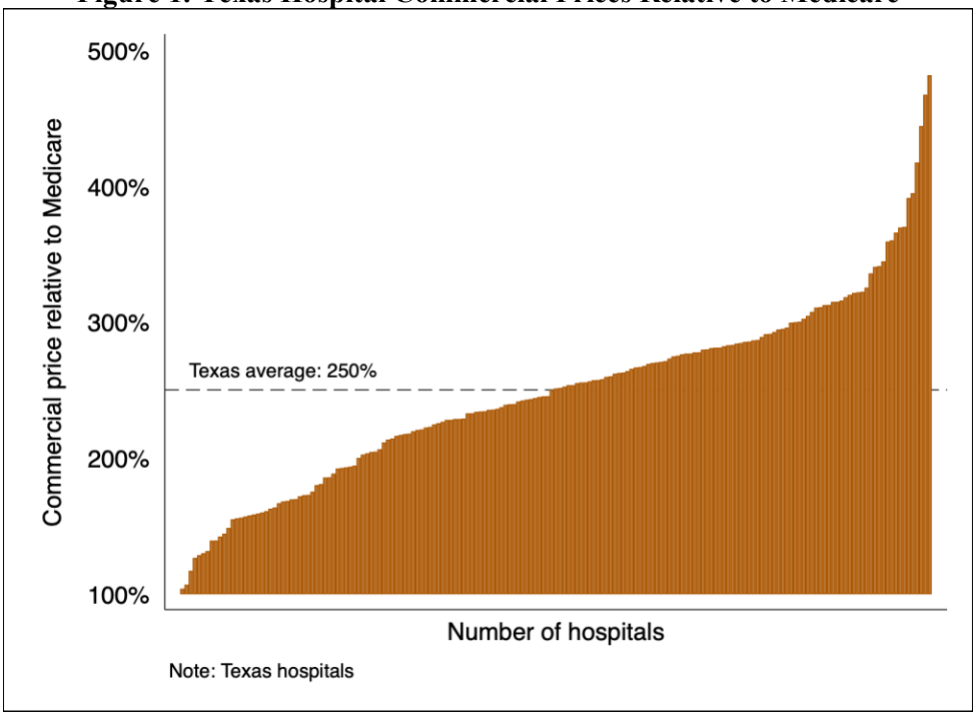
These patterns are also prevalent in Texas. As shown in Figure 1, commercial insurance prices for Texas hospitals average approximately 250% of Medicare rates, but vary by a factor of five. This wide variation in prices among Texas hospitals is not linked to hospital quality. Hospital prices in Texas are also not explained by differences in payor mix or uncompensated care patient volume. Texas hospitals with the

[2] Centers for Medicare & Medicaid Services. National health expenditure data. Centers for Medicare & Medicaid Services. Published December 18, 2024. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

[3] Perry M. Chart of the Day . . . or Century? American Enterprise Institute - AEI. Published July 23, 2022. https://www.aei.org/carpe-diem/chart-of-the-day-or-century-8/.

highest shares of non-commercial patients have similar prices as those with mainly publicly insured patients.[4]

Figure 1: Texas Hospital Commercial Prices Relative to Medicare



Source: Analysis of data published in Whaley CM, et al, Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. Published December 10, 2024.

Why are prices growing so rapidly? The U.S. hospital market is characterized by two unique features. First, it has been shaped by decades of consolidation, resulting in a landscape that is highly concentrated. The U.S. has seen over 2,000 hospital mergers since 2001. Nearly all U.S. hospital markets exceed the market concentration definitions used by regulators such as the U.S. Department of Justice and Federal Trade Commission to classify highly concentrated markets (Figure 2).[5] In Texas, one-third of hospitals have been participants in merger and acquisition activity over the last decade. A large set of rigorous studies conclusively demonstrates that hospital mergers raise prices without improving quality.[6,7] To illustrate this, Figure 3 shows Texas hospitals by their CMS hospital star rating (a measurement of hospital quality) and the hospital's commercial prices as a percentage of Medicare rates.

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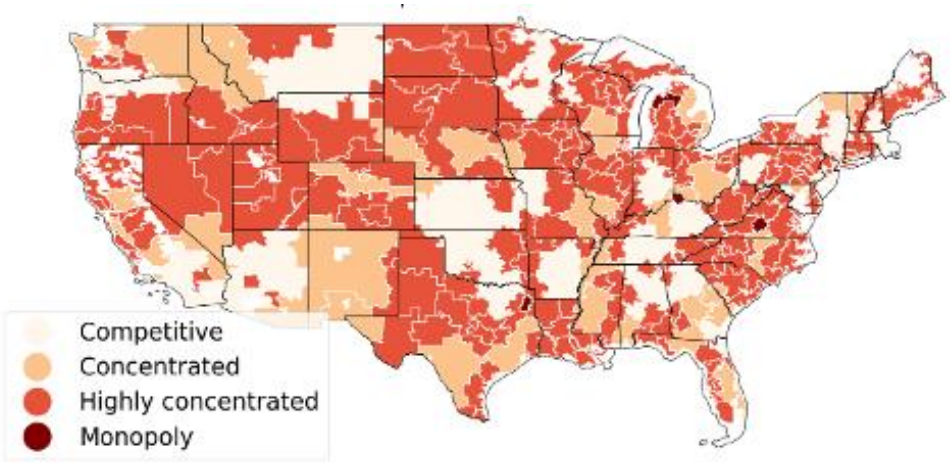
[4] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024. Accessed September 3, 2025. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

[5] Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Aff (Millwood)*. 2017;36(9):1530-1538. doi:10.1377/hlthaff.2017.0556

[6] Whaley C, Singh Y, Fuse Brown EC, Reddy M, Perkins J, Rooke-Ley H. *Addressing Healthcare Consolidation in the U.S-Potential Policy Options for a Competitive and Transparent Future Policy Brief*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf

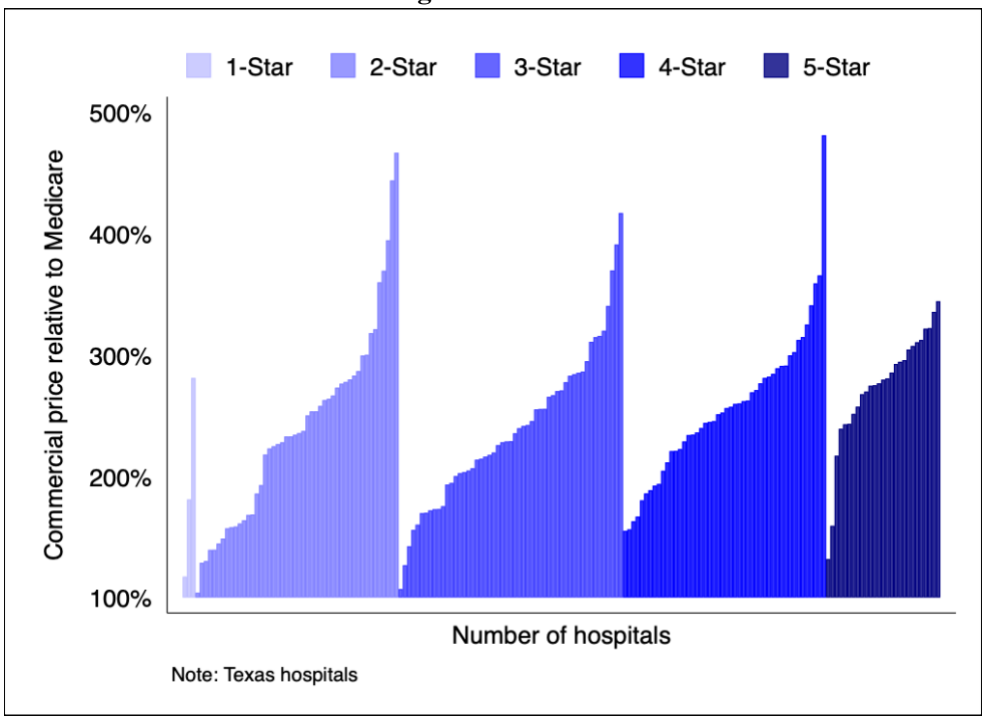
[7] Liu, Jodi L., Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi, Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1820-1.html.

Figure 2: Hospital Market Concentration by Geographic Market



Source: Analysis of 2022 American Hospital Association data. Geographic markets defined using Hospital Referral Regions (HRRs). Market concentration is defined using the Hirschman Herfindahl Index (HHI), with ranges of Competitive (less than 1,800), Concentrated (1,800 to 2,500), Highly concentrated (above 2,500), and Monopoly (10,000).

Figure 3: Texas Hospitals by CMS Star Rating and the Hospital's Commercial Prices as a Percentage of Medicare Rates



Source: Analysis of data published in Whaley CM, et al, Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024.

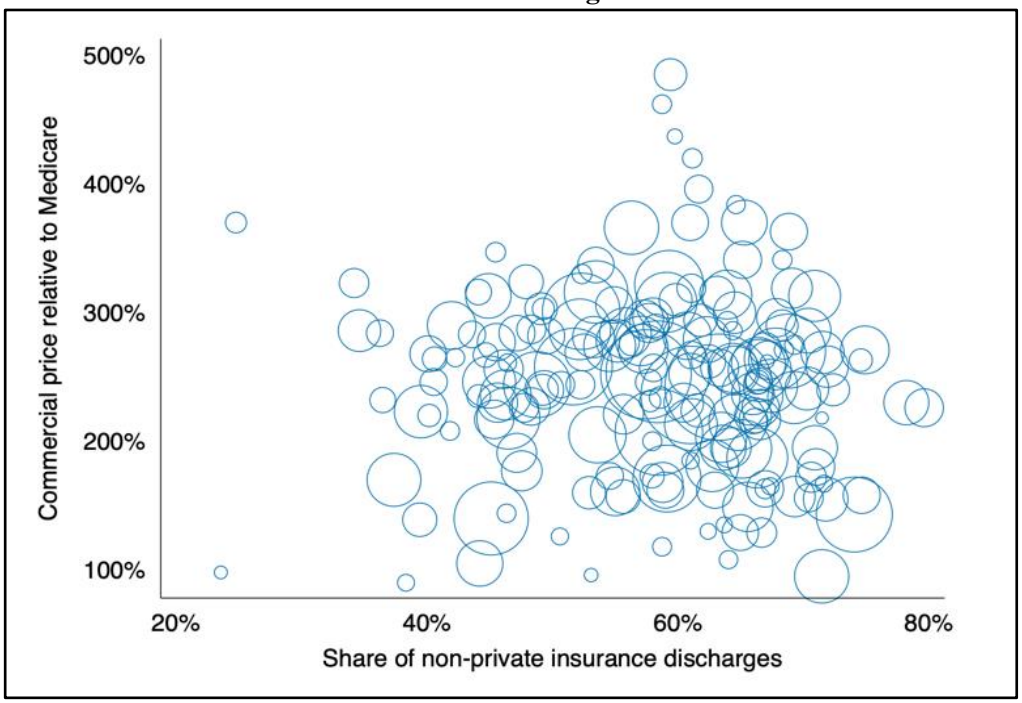
In part due to decades of consolidation, patients with commercial insurance nationally pay approximately 250 percent of what Medicare pays for hospital care.[8] High commercial insurance prices are paid by

[8] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024. Accessed September 3, 2025. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

patients both through cost-sharing payments, as well as through higher premiums and lower wages.[9] Operating margins for commercially insured patients receiving care at system-affiliated hospitals are over 40 percent.[10] My research also shows how hospital mergers increase financial instability among neighboring hospitals.[11]

A common justification for commercial hospital prices is that high prices are necessary to offset losses on patients who have no insurance or who are publicly-insured. If this "cost-shifting" argument were true, hospitals with the highest percentages of Medicaid, Medicare, and uninsured patients would have the highest commercial prices. However, my research has shown that this is not the case. To illustrate this, Figure 4 shows Texas hospitals mapped by the share of their discharged patients who are not privately insured (including Medicaid, Medicare, and uninsured patients) and the hospital's commercial prices as a percentage of Medicare rates. Counter to the argument that cost-shifting drives prices, there is no relationship between hospital case mix and commercial insurance prices.[12] Instead, high hospital prices are associated with greater provider market power and market share, rather than patient makeup or hospital quality.[13]

Figure 4: Texas Hospitals by Non-Privately Insured Patient Discharges and the Hospital's Commercial Prices as a Percentage of Medicare Rates



[9] Arnold D, Whaley C. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. *SSRN Electronic Journal*. Published online 2020. doi:https://doi.org/10.2139/ssrn.3657598

[10] Whaley C, Bartlett M, Bai G. Financial Performance Gaps Between Critical Access Hospitals and Other Acute Care Hospitals. *JAMA Health Forum*. 2024;5(12):e243959. Published 2024 Dec 6. doi:10.1001/jamahealthforum.2024.3959

[11] Arnold D, Radhakrishnan N, Whaley C. Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization . *SSRN*. Published online May 22, 2025. doi:https://doi.org/10.2139/ssrn.5265291

[12] Frakt AB. How much do hospitals cost shift? A review of the evidence. Milbank Quarterly. 2011; 89(1):90-130.

[13] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024. Accessed September 3, 2025. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

Source: Analysis of data published in Whaley CM, et al, Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. RAND Corporation. Published December 10, 2024.

In addition to hospital mergers, health care markets have become highly vertically consolidated, which further tilts market power towards hospitals. The share of U.S. physicians employed by a hospital or health system conglomerate has roughly doubled since 2010, with over half of U.S. physicians now working for a health system. My research shows that acquiring physician practices presents hospitals with an arbitrage opportunity to exploit the site-of-care payment differential by charging higher hospital-based rates for routine outpatient services performed by, or referred by, acquired physicians.[14,15,16,17] The Congressional Budget Office estimates that addressing site-of-care payment differentials could reduce Medicare spending by over $150 billion nationally.[18] My research shows that if Texas were to enact legislation preventing site-of-care payment differentials for services that could safely be delivered in outpatient settings, Texas patients and insurance purchasers would save approximately $500 million annually.[19]

Second, U.S. hospitals vary between for-profit and nonprofit firms. 61 percent of US hospitals are tax-exempt, compared to 17 percent of hospitals that are for-profit and 22 percent that are government hospitals. Like nonprofits in other industries, nonprofit hospitals have the financial benefit of not paying taxes, including federal, state, local, and municipal taxes.[20] Tax exemptions include corporate income, unemployment, and property taxes. In addition, tax-exempt hospitals may receive tax-exempt charitable donations and issue tax-exempt bonds. Nonprofit hospitals' tax exemptions are divided almost equally between federal and state taxes. Notably, nonprofit hospitals also have access to the 340B discount program, which allows hospitals and associated entities to purchase drugs at rebated prices. These savings are not passed on to patients.[21] Additionally, many tax-exempt hospitals have also been dually classified as both rural and urban hospitals, allowing them to receive increased Medicare payments.[22]

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[14] Whaley CM, Zhao X. The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics. *J Public Econ*. 2024;238:105175. doi:10.1016/j.jpubeco.2024.105175

[15] Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *J Health Econ*. 2022;81:102569. doi:10.1016/j.jhealeco.2021.102569

[16] Whaley CM, Zhao X, Richards M, Damberg CL. Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration. *Health Affairs*. 2021;40(5):702-709. doi:https://doi.org/10.1377/hlthaff.2020.01006

[17] Whaley C, Singh Y, Fuse Brown EC, Reddy M, Perkins J, Rooke-Ley H. *Addressing Healthcare Consolidation in the U.S-Potential Policy Options for a Competitive and Transparent Future Policy Brief*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf

[18] Congressional Budget Office (CBO). Reduce Payments for Hospital Outpatient Departments | Congressional Budget Office. cbo.gov. Published December 12, 2024. https://www.cbo.gov/budget-options/60908

[19] Murray RC, Janjua H, Whaley CM. Site-neutral payment for routine services could save commercial purchasers and patients billions. *Health Affairs Scholar*. 2025;3(12). https://doi.org/10.1093/haschl/qxaf241.

[20] Godwin J, Levinson Z, Hulver S. The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020 | KFF. KFF. Published March 14, 2023. Accessed September 12, 2025. https://www.kff.org/health-costs/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/

[21] Robinson JC, Whaley CM, Dhruva SS. Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance. *New England Journal of Medicine.* 2024;390(4):338-345. doi:10.1056/NEJMsa2306609.

[22] Wang Y, Perkins J, Whaley CM, Bai G. Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23. *Health Affairs*. 2025;44(8):963-969. doi:https://doi.org/10.1377/hlthaff.2025.00019

State Policies to Improve Health Care Affordability

To address high and rising hospital prices, states have taken a variety of approaches to improve affordability in their health care sectors. These approaches have included placing caps on maximum hospital prices, strengthening state review authority for large-scale health care transactions, and mandating the disclosure of ownership interests in providers. Each of these policies requires transparent data on provider prices and market structure.

Price Regulation to Limit Impacts of Hospital Consolidation

While regulators are often hesitant to intervene in markets, the rapid rise of hospital prices and degree of consolidation has led many states to pursue policy interventions to improve affordability by directly regulating or capping hospital prices. Rhode Island was among the first states to adopt this approach, implementing Affordability Standards in 2010 that, among other things, limit annual growth in hospital facility fees. The Affordability Standards cap annual increases in hospital prices at inflation plus one percentage point. Even though the price growth limits apply only to fully-insured plans, the evidence suggests that the policy also led to price reductions across insurance companies' self-insured business, as well. In joint work with my colleagues at Brown, we found that the Standards were associated with a 9.1% average reduction in hospital facility fees and a 6.5% average reduction in fully-insured premiums over an eleven-year period. We further estimate that these price and premium reductions translated into approximately $87.7 million in annual savings in the fully-insured market, totaling $1.14 billion in cumulative savings from 2010 through 2022.[23] However, our research found that these constraints also reduced hospital revenues, potentially contributing to lower operating margins for Rhode Island hospitals relative to hospitals in surrounding New England states, alongside other factors such as cuts to Medicaid payments.

Other states have pursued hospital price regulation by setting service-level price caps. Oregon was the first state to do this through legislation. Since 2019, the state has capped hospital prices paid by the state employee health plan at 200% of Medicare payments for in-network services and 185% for out-of-network services.[24] Patients cannot be charged more than their in-network cost-sharing amounts. The legislation applies to 24 of Oregon's large, urban hospitals and exempts critical access hospitals and other small and rural hospitals in the state. In our evaluation of Oregon's policy, we found that outpatient facility prices paid by the state employee plan decreased by 25%, while inpatient facility prices dropped by 3%, resulting in $107.5 million in savings for the state over the first two years and three months—about 4% of total plan spending.[25] Enrollees in higher cost-sharing plans experienced a 9.5% reduction in

[23] Ryan AM, Whaley CM, Fuse Brown EC, Radhakrishnan N, Murray RC. Rhode Island's affordability standards led to hospital price reductions and lower insurance premiums. Health Aff (Millwood). 2025;44(5):597-605.

[24] Oregon State Legislature. 79th Oregon Legislative Assembly—2017 Regular Session, SB 1067 enrolled, Relating to government cost containment; and declaring an emergency, Chapter 746 [Internet]. Salem (OR): The Legislature; [cited 2024 Feb 12]. Available from: https://olis.oregonlegislature.gov/liz/2017R1/Measures/Overview/SB1067.

[25] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024; 43(3).

out-of-pocket spending, with only slight increases in service use, which provides early evidence that state employee members are not experiencing challenges in accessing care.[26]

To date, all 24 hospitals have remained in the state employee plan's network, and none have closed. In line with a broader body of research, we found no evidence of "cost-shifting" to commercial plans during the first two years and three months of the cap; facility prices for non-state employee commercial enrollees at the 24 hospitals were not statistically different from prices at Oregon's non-exposed hospitals from October 2019 through December 2021.[27] Further, our more recent analysis has found that Oregon's payment cap had a minimal impact on hospital finances (about a 1% reduction in hospital net patient revenue, on average), and thus, had no negative impact on hospital operations, staffing, or patient experience of care.[28] These findings suggest that Oregon's hospitals have been able to improve health care affordability for state employees and their dependents and still cover their costs and keep their doors open.

Building off the experience of Oregon, a broad range of states have taken action to cap hospital prices. In 2025, the State of Washington joined Oregon to become the second state to adopt a service-level cap on hospital payments by its state employee health plan through legislation.[29] Like the Oregon law, the Washington law limits prices to 200% of Medicare payments for in-network services and 185% for out-of-network services. Also in 2025, Indiana and Vermont became the first two states to enact legislation to cap hospital prices across ***all*** commercial payers. Indiana's law requires nonprofit hospitals to bring their aggregate average inpatient and outpatient prices under statewide averages by June 2029. Any nonprofit hospital that fails to meet this requirement will have to forfeit its nonprofit status until it can lower prices below the average.[30] Vermont's new law directs the Green Mountain Care Board, an independent board responsible for regulating and evaluating the state's health care system, to establish by 2027 upper limits on the amounts that hospitals can accept as payment for health care services, based on a percentage of Medicare rates.[31] This year, bills to establish commercial-wide caps on hospital prices have been filed in states ranging from Maine[32] to Oklahoma[33] to Massachusetts.[34]

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[26] Murray RC, Norton EC, Ryan AM. Oregon's hospital payment cap and enrollee out-of-pocket spending and service use. JAMA Health Forum. 2024;5(8):e242614. doi:10.1001/jamahealthforum.2024.2614 .

[27] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024; 43(3).

[28] Murray RC, Ryan AM, Whaley CM. Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented. Health Aff (Millwood). 2025;44(12):1482-9.

[29] Senate Bill 5083: Ensuring access to primary care, behavioral health, and affordable hospital services [Internet]. Wash. 69th Leg., Reg. Sess. (2025). Available from: https://app.leg.wa.gov/billsummary?BillNumber=5083&Year=2025&Chamber=Senate.

[30] House Bill 1004: health care matters [Internet]. 124th Gen. Assemb., Reg. Sess. (IN 2025). Available from: https://iga.in.gov/legislative/2025/bills/house/1004/details.

[31] S.126: An act relating to health care payment and delivery system reform [Internet]. 69th Gen. Assemb., Reg. Sess. (VT 2025-2026). Signed by Governor June 12, 2025 (Act 68). Available from: https://legislature.vermont.gov/bill/status/2026/S.126.

[32] LD 2196: An Act to Lower Health Insurance Costs, Reduce Barriers to Health Care and Ensure Fair Prices for Health Care. Maine's 132nd Legislature (2026). Available from: https://legislature.maine.gov/billtracker/#Paper/HP1475?legislature=132.

[33] HB 3196: An Act relating to revenue and taxation. Oklahoma's 2nd Session of the 60th Legislature (2026). Available from: http://www.oklegislature.gov/BillInfo.aspx?Bill=HB3916&session=2600.

[34] Bill S.902: An Act lowering health care costs for patients. Massachusetts' 194th General Court (2026). Available from: https://malegislature.gov/Bills/194/SD1569.

Given the wide range of prices among Texas hospitals and the lack of a relationship between hospital price and quality, these policies could also be implemented by Texas. In a recent study, my colleagues and I estimated that implementing a policy similar to Oregon's and limiting hospital prices for Texas state employees would reduce health care spending by $180 million annually.[35] These savings could be used to improve wages and other benefits for Texas state employees or reduce tax burdens for Texans.

Merger and Consolidation Transaction Review

Despite research showing that consolidation increases health care costs, much health care consolidation remains almost entirely opaque and unreviewed.[36] Existing federal and state oversight mechanisms are limited. Many health care transactions fall below federal Hart-Scott-Rodino Act reporting thresholds ($133.8 million in 2026)[37] and escape antitrust scrutiny.[38] Historically, reviews by state attorneys general have tended to focus on nonprofit hospital mergers and have not captured or corporate consolidation by for-profit investors or physician practice acquisitions involving management services organization (MSO) models that involve contractual controls instead of formal acquisition.[39]

More recently, states are stepping up to fill the gap, enacting legislation to provide transparency into the major ownership changes that affect local health care markets.[40] Some states—including Oregon, Massachusetts, and New Mexico—have enacted policies to strengthen and expand health care transaction oversight.[41] And a variety of other states are seeking to follow suit in 2026. Legislation is being

[35] Murray RC, Whaley CM, Fuse Brown EC, Ryan AM, Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy. *Health Aff (Millwood)*. 2024;43(12):1680-1688. doi:https://doi.org/10.1377/hlthaff.2024.00691.

[36] Yashaswini Singh and Erin Fuse Brown, "The Missing Piece In Health Care Transparency: Ownership Transparency," September 22, 2023, https://doi.org/10.1377/forefront.20230921.886842.

[37] "FTC Announces 2026 Update of Jurisdictional and Fee Thresholds for Premerger Notification Filings," Federal Trade Commission, January 14, 2026, https://www.ftc.gov/news-events/news/press-releases/2026/01/ftc-announces-2026-update-jurisdictional-fee-thresholds-premerger-notification-filings.

[38] Thomas Wollmann, *How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare*, no. w27274 (National Bureau of Economic Research, 2020), w27274, https://doi.org/10.3386/w27274.

[39] Fuse Brown and Gudiksen, *Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities*.

[40] Erin Fuse Brown and Katherine Gudiksen, *Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities* (Milbank Memorial Fund, 2024), https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/.

[41] Hostert N. How States Strengthened Their Health Care Markets in the 2025 Legislative Session. Milbank Memorial Fund. 2025. https://www.milbank.org/publications/how-states-strengthened-their-health-care-markets-in-the-2025-legislative-session/.

considered in Colorado,[42] Illinois,[43] Iowa,[44] Maine,[45] Pennsylvania,[46] and Vermont[47] to require prior notification and review of significant health care transactions.

Ownership Transparency

Many current structures of health care provider ownership are opaque, leaving patients without the ability to fully understand who employs their doctor. As private equity firms and other for-profit actors become increasingly involved in the health care sector, states are seeking ways to bring transparency to the ownership structure of health care entities. Most states do not routinely collect information on the ownership of health care entities, leaving them without the ability to understand the penetration of entities like private equity firms in their health care systems. As concern is growing about the threats of private equity in the health care sector, states have begun to adopt transparency rules to require the systematic disclosure of the ownership and control of health care providers. Such policies have been adopted in Massachusetts,[48] Indiana,[49] and—as of this year—Maine.[50]

Price Transparency

In addition to expanded transparency around provider ownership, these efforts require accurate information on negotiated prices. Health care prices are notoriously opaque to those that pay the bills—employers, consumers, and both state and federal governments. Many commercial payers consider price information to be a trade secret, and gag clauses commonly prohibit disclosure of the prices paid to providers. Although it is ethical to provide patients with price information, research shows that consumers do not often effectively use price transparency to shop for care.[51] The lack of transparent, usable price information hinders the ability of researchers to understand competition dynamics and the impacts on cost and quality. It also hinders the ability of entrepreneurs to develop new benefit design innovations to help control spending, and of policymakers to oversee market conduct and competition. The lack of transparent pricing also creates barriers to understanding the drivers of health care costs and designing

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[42] Consumer Protections Medical Care Entities, SB26-041, Colorado State Legislature, 2026 Regular Session, https://leg.colorado.gov/bills/SB26-041

[43] SB 1998, Illinois General Assembly, 104th General Assembly, https://www.ilga.gov/Legislation/BillStatus?GAID=18&DocNum=1998&DocTypeID=SB&LegId=0&SessionID=114.

[44] SF 414, Iowa Legislature, 91st General Assembly, https://www.legis.iowa.gov/legislation/BillBook?ba=SF414&ga=91.

[45] LD 2201, 132nd Maine Legislature, Second Regular Session, https://legislature.maine.gov/bills/display_ps.asp?snum=132&paper=HP1480PID=1456.

[46] An Act Providing for Approval from the Department of Health and the Office of Attorney General before Certain Transactions Involving Health Care Entities within This Commonwealth., Senate Bill 322, Pennsylvania General Assembly 2025-2026 Regular Session, https://www.palegis.us/legislation/bills/2025/sb322.

[47] An Act Relating to Health Care Entity Transaction Oversight and Clinical Decision Making, H. 71, Vermont General Assembly (2025), https://legislature.vermont.gov/bill/status/2026/H.71.

[48] Hostert N, Mehta N, Rooke-Ley H, Singh Y, Fuse Brown EC. How Massachusetts's New Health Care Reform Takes Aim at Private Equity. Health Aff Forefront. 2025 May. Available from: https://www.healthaffairs.org/content/forefront/massachusetts-s-new-health-care-reform-takes-aim-private-equity.

[49] HB 1666, Indiana General Assembly, 2025 Session, https://iga.in.gov/legislative/2025/bills/house/1666/details.

[50] LD 2201, 132nd Maine Legislature, Second Regular Session, https://legislature.maine.gov/legis/bills/display_ps.asp?LD=2201&snum=132.

[51] Whaley C, Frakt A. If Patients Don't Use Available Health Service Pricing Information, Is Transparency Still Important? *AMA J Ethics*. 2022 Nov 1;24(11):E1056-1062. doi: 10.1001/amajethics.2022.1056. PMID: 36342488; PMCID: PMC10861144.

solutions. Rather than placing the responsibility of putting downward pressure on health care spending on consumers who are trying to navigate the complex payment system,[52] price transparency can be an effective tool to enable policymakers to design impactful programs and policies.

In addition to federal efforts to expand price transparency through the Transparency-in-Coverage requirements, several states have collected and reported data through state all-payer claims databases (APCDs). Currently, 25 states operate an APCD, and state APCDs vary in scope and breadth. The recently-implemented APCD in Texas has the opportunity to inform data-driven policy making. Ensuring these data are available and can be used to transparently identify high-priced providers is critical for policy and regulatory decisions that seek to improve the affordability of health care for Texans and improve the function of Texas health care markets.

Conclusion

Hospitals are a critical component of the U.S. health care system and the U.S. economy. Access to affordable and high-quality hospital care is critical for the health and well-being of the American population. Yet, rising prices, particularly driven by hospital prices, threaten health care affordability in the United States and for Texans. High and variable health care prices are not consistently linked to quality or underlying cost structures. To ensure health care markets deliver high-quality and affordable care for Texans, it is important for Texas policymakers to monitor and prevent future consolidation of the Texas delivery and insurance systems.

Several states have more directly addressed health care affordability by limiting the rates that dominant health systems can charge patients. While these policies represent a significant intervention into health care markets, policymakers in states ranging from Indiana to Vermont have reasoned that U.S. hospital markets are currently flawed enough to warrant such intervention. Health care markets in every state, including Texas, are unique. It is critical that Texas policymakers consider their specific market environment and context when addressing health care affordability. The nascent Texas all-payer claims database can be a resource to ensure these policy decisions are driven by accurate and representative data.

[52] Chernew M, Cooper Z, Hallock EL, and Scott Morton F. Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans. *Journal of Health Economics*. Vol. 76. 2021.