

A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market

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BROOKINGS

Abstract

The United States not only spends a larger share of its GDP on health care than any other country but also has experienced more rapid health-care spending growth over time. The high private sector health-care spending in the United States relative to that in other developed countries is driven mostly by higher prices. While the United States will likely continue to rely largely on markets to allocate health-care resources, overall market forces have not been sufficient to contain commercial provider prices. Thus, some form of public sector intervention may be needed. In this proposal, we discuss how price regulation could be used to constrain commercial provider prices with relatively smaller market distortions than would likely occur under alternative approaches, such as a public insurance option. We develop a proposal whose parameters can be adjusted to reflect stakeholder and policymaker objectives. We also discuss key implementation challenges. We recommend a three-pronged approach that includes market- and service-specific price caps that apply directly to the very top of the commercial price distribution; service-, insurer-, and provider-specific price growth caps that constrain price inflation; and flexible oversight by state and/or federal authorities to address potential evasion.

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Introduction

The United States spends a larger share of its GDP on health care than any other country—a fact that many studies have linked to our relatively high prices rather than to higher utilization of care or to a greater burden of disease (Laugesen and Glied 2011). Recent studies also find that the growth in U.S. health-care spending is largely due to growth in prices for commercially insured patients (Cooper et al. 2019; Health Care Cost Institute 2019). Moreover, there is scant evidence that high U.S. provider prices reflect better quality of care. However, serious discussion about using legislation to contain provider prices to date focuses largely on the most egregious market failure: surprise billing, whereby a patient receives an out-of-network (OON) bill for a service delivered at an in-network (INN) facility. While surprise billing is an important issue (Bluth 2019), such bills represent only a modest portion of the broader provider pricing problem (Chernew, Pany, and Frank 2019). Because market forces have not yielded competitive commercial provider prices, we believe policy intervention is necessary. The key question is what form that action should take.

PRICES INFLUENCE HOW AND WHAT CARE IS DELIVERED

Prices are central to any economic system because they convey information to all stakeholders about the value of any service (what consumers are willing to pay) and the cost of production (what providers are willing to accept in exchange for the service). The price of any health-care service conveys how much it is worth relative to both non-health-care services and other health-care services. High prices for health care relative to non-health-care services imply that we value health care sufficiently to draw resources from other sectors of the economy into health care. Moreover, high relative prices within the health-care sector divert resources from some activities toward others. Prices act not only to direct resources to specific providers or services

but also to encourage greater production of and investment in services that are more highly remunerated (relative to costs). For example, if we decide that hospitals should receive more revenue and to realize that objective we pay more for inpatient surgery, we not only generate more revenue for hospitals but also encourage hospitals to perform more inpatient surgeries than they otherwise would and thereby stimulate investment in additional resources to support these surgeries. A similar revenue goal could be met by paying hospitals more for outpatient care, in which case we would encourage more outpatient care instead. Thus, relative prices have consequences, even when average price levels are held constant.

In a well-functioning market, competition drives prices to the efficient level, and the information conveyed by prices reflects the relative values of the goods and services sold. In health-care markets, a number of distortions result in prices that do not convey this information. These distortions exist in both the public and private sectors. Given the well-documented problems with absolute and relative commercial prices for health-care services in the United States, a strong case can be made for a policy intervention.

Price setting by public payers is widespread: Medicare and Medicaid have been setting prices for decades. Yet, explicit regulation of commercial prices is relatively rare—the notable exceptions include regulation of surprise bills in some states such as California and New York and all-payer rate setting in Maryland—although frustration with the status quo has heightened interest in potential policy solutions. However, few specific proposals for price regulation have been offered, and few frank discussions have addressed the trade-offs inherent in the different possibilities.

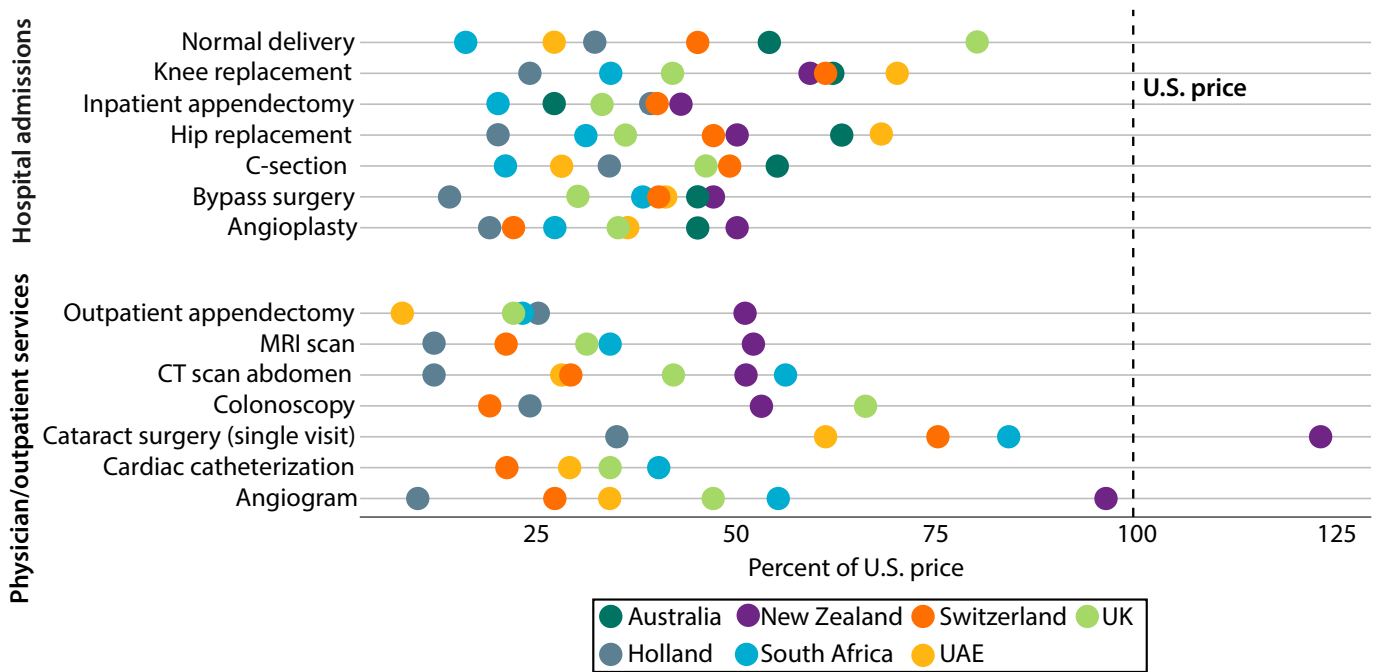
The Challenge

The core challenge we seek to address is how to constrain high and rising commercial prices for health-care services. U.S. prices are both high (by international standards; see figure 1) and highly variable (figures 2a and 2b shows examples). Prices vary substantially across markets, across providers within markets, and even within providers across insurance contracts (Cooper et al. 2019). Some portion of this variation reflects natural variation in market-specific resource costs (e.g., wages or rents), production efficiency, and perhaps health-care quality. A significant portion of this variation, however, reflects market power and market failures. A key challenge in addressing high and rising health-care prices lies in eliminating the component that is due to imperfect markets while preserving the variation inherent in, and essential to, a market-based health-care delivery system.

MARKET FAILURES IN HEALTH CARE: WHY IT IS SO HARD TO GET PRICES RIGHT

Relying on markets is difficult in health care for several reasons. Insurance dampens incentives for consumers to seek low prices, and information problems make price shopping difficult. Information problems arise because health care is complex and all patients are different. Although some services are commoditized, most often there is no “one-size-fits-all” treatment. Moreover, the quality or appropriateness of care is both important and hard to observe. As a result, patients may be hesitant to visit low-price providers if they are unsure of the quality (and may even consider high prices to be a signal of high quality; Waber et al. 2008). Decades of work has demonstrated that our market-based, decentralized health-care system leads to high prices that seem far from efficiently determined.

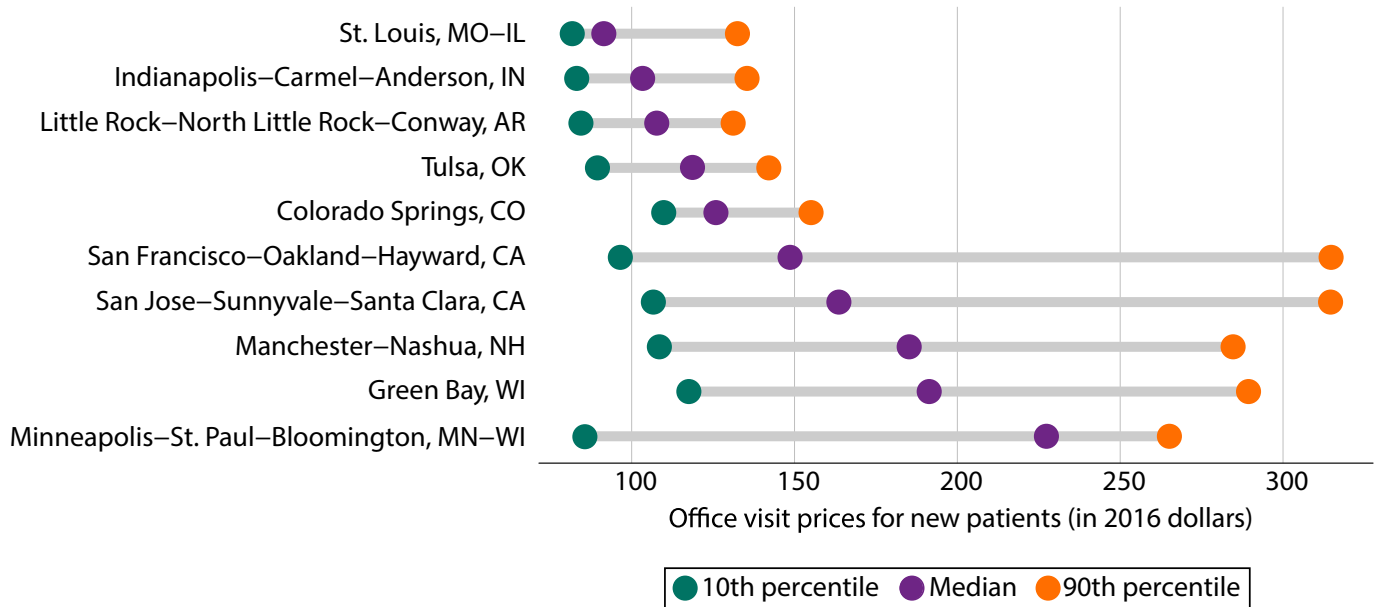
FIGURE 1.
International Medical Prices for Selected Services as a Percentage of U.S. Price



Source: Adapted from Hargraves and Bloeschichak (2019) using International Federation of Health Plans (IFHP) data.
Notes: Data are from IFHP member companies in eight countries. International service price comparisons are complicated by potentially different service definitions, reimbursement arrangements, and health plan participation across countries.

FIGURE 2A.

Service Price Variation within Metro Area for Office Visits with A New Patient



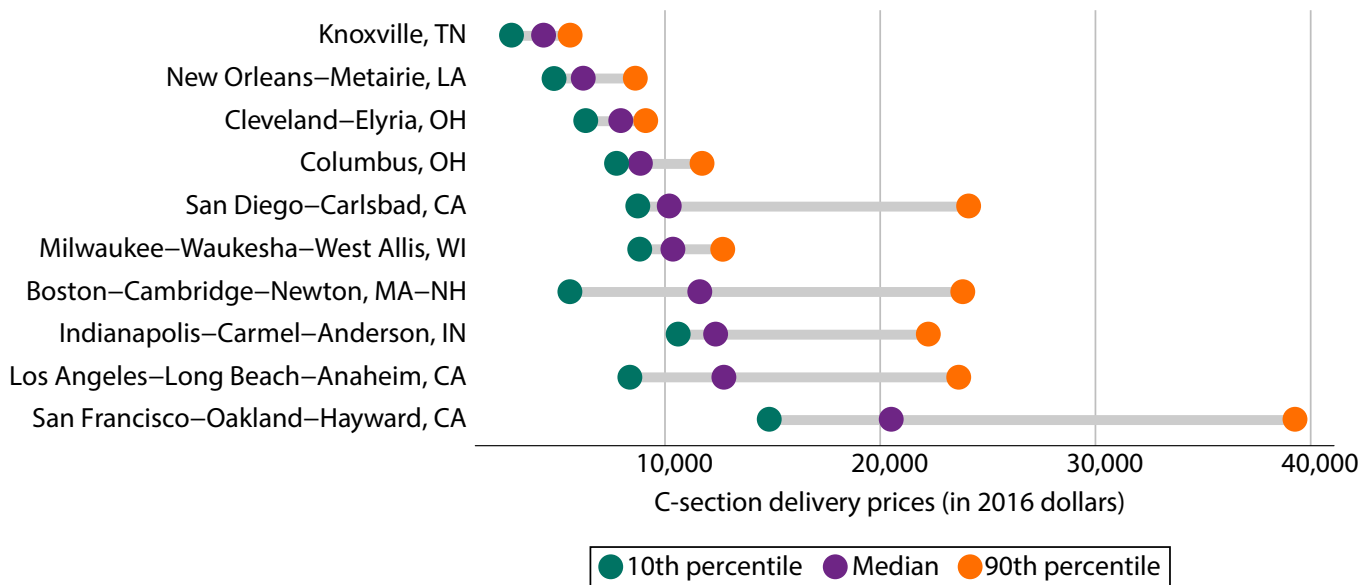
Source: Adapted from Kennedy et al. (2019) using Health Care Cost Institute data.

Notes: Percentiles (10th, median, 90th) show within-metro variation in price for the indicated service. Metro areas are defined as the 112 core-based statistical areas in the United States. A select group of metro areas is shown.

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FIGURE 2B.

Service Price Variation within Metro Area for C-section Delivery



Source: Adapted from Kennedy et al. (2019) using Health Care Cost Institute data.

Notes: Percentiles (10th, median, 90th) show within-metro variation in price for the indicated service. Metro areas are defined as the 112 core-based statistical areas in the United States. A select group of metro areas is shown.

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One key source of high prices in the United States is provider market power (Gaynor, Ho, and Town 2015). By one common, albeit flawed, measure of market competitiveness, U.S. health care performs very poorly: 90 percent of metropolitan statistical areas (MSAs) were highly concentrated for hospitals and 65 percent were highly concentrated for specialist physicians in 2016 (Fulton 2017). A substantial economic literature has also demonstrated that provider consolidation leads (on average) to “less bang for the buck”: higher prices without higher quality or access (Beaulieu et al. 2020; Dafny 2018).

The health insurance industry is locally concentrated as well, although at least one study has found less concentration than in the provider sector: in 58.4 percent of MSAs, provider concentration was higher than insurer concentration, with the opposite true only in 5.8 percent of MSAs (Fulton, Arnold, and Scheffler 2018). Economists have also demonstrated that insurer mergers yielding increases in local insurance market concentration can result in higher health insurance premiums (Dafny, Duggan, and Ramanarayanan 2012; Guardado, Emmons, and Kane 2013). While larger insurers on average negotiate lower provider prices, their ability to do so is counterbalanced by provider market power and employers’ preferences for broad networks (Kaiser Family Foundation 2019). Relying on the balance of power between insurers and providers has not yielded commercial prices that reflect value. Thus, policymakers wishing to reform U.S. health care must address high and rising provider prices in the commercial sector.

STRATEGIES THAT PROMOTE PROVIDER COMPETITION, ALTHOUGH VALUABLE, ARE UNLIKELY TO REIN IN PRICES ON THEIR OWN

A common approach to restraining high prices in health care is to augment competitive forces. Pro-competitive strategies are generally aimed at increasing patient price shopping and provider competition. Specific proposals differ and include initiatives related to price transparency, insurance benefit design, risk-based contracts, strengthening antitrust enforcement, and limiting anticompetitive contracting practices.

Efforts to heighten price transparency include mandatory price reporting and deployment of tools to allow patients to compare prices across providers. These efforts aim to incentivize patients to shop for lower-priced services, in turn incentivizing providers to compete on price. Evidence on the effectiveness of price transparency initiatives has been discouraging to date: when given the opportunity, few patients used company, insurer, or state tools to compare prices (Desai et al. 2017; Mehrotra, Brannen, and Sinaiko 2014; Mehrotra, Chernew, and Sinaiko 2018). Without a critical number of patients actively comparing prices, transparency may fail to

rein in high-price providers. Moreover, price transparency could inadvertently result in *higher* prices because the public disclosure of formerly confidential prices can create perverse incentives for providers *not* to offer low prices to select insurers (Cutler and Dafny 2011).

Insurance benefit design attempts to incentivize price shopping by making patients more price sensitive, effectively removing some of the financial protections of insurance. Most widespread are high-deductible health plans, which leave enrollees responsible for the full cost of care under the deductible. Research shows that high-deductible health plans reduce overall spending by reducing the amount of care patients seek, but are ineffective at encouraging price shopping (Mehrotra, Chernew, and Sinaiko 2018). Another common strategy is to offer a narrow or tiered network plan, under which cost-sharing is higher (or complete) for higher-tiered (or excluded) providers. These plans have been shown to lower spending by affecting provider choice (Frank et al. 2015; Sinaiko, Landrum, and Chernew 2017). Network design affects insurer-provider contracting and thus has the potential to directly lower provider prices as well (as opposed to just shifting patients to lower-price providers), but evidence has only begun to emerge (Prager 2015) and diffusion has not been significant in the employer market (Kaiser Family Foundation 2019). Reference pricing, which provides first-dollar coverage up to a specified amount after which the insured is fully responsible, has been shown to encourage price shopping and to reduce provider prices for some conditions, such as orthopedic surgery (Robinson and Brown 2013). However, its complexity, together with concerns over shifting excessive risk onto patients, has prevented widespread diffusion (Sinaiko, Alidina, and Mehrotra 2019).

On balance, evidence suggests that targeted benefit design approaches can lead to reductions in provider prices, but the most targeted approaches have been slow to diffuse in the commercial market, perhaps because employers are wary of the risk they transfer to employees or because of the complexity of implementation. On their own, changes in benefit design have not managed to overcome the misaligned incentives and information asymmetries fundamental to health care.

Risk-based contracts financially incentivize providers to lower spending (through reduced prices or quantity) and to maintain or improve quality. In the commercial market, some of the most successful risk-based contracts encourage independent primary care physician groups to seek lower-priced specialty or hospital care. One example is the Alternative Quality Contract covering commercial Blue Cross Blue Shield patients in Massachusetts. Evidence suggests that these contracts have reduced care volume without diminishing quality by setting an annual spending

target and requiring providers to share risk, incurring savings from spending less and losses from spending more than the target (McWilliams et al. 2016; Song et al. 2019). Payments are conditional on meeting quality standards. The Alternative Quality Contract also induced changes in referral patterns to lower-price providers, a form of price shopping, but evidence of reductions in prices charged by providers is scant.

Antitrust enforcement vis-à-vis health-care providers, as in other sectors, focuses on blocking anticompetitive mergers and acquisitions as well as other anticompetitive conduct. Federal enforcement agencies currently have a strong record of challenging horizontal provider mergers, that is, mergers of providers competing head-to-head to provide the same service(s) in the same geographic market. However, this record was preceded by some significant losses in the 1990s, and followed by a decade of minimal enforcement until a reinvigorated and revamped approach took hold with the 2008 *Evanston* decision (Capps 2014). Thus, even the agencies' current success cannot address consolidation that has already occurred, barring other anticompetitive and illegal actions by such entities.¹ In addition, federal authorities are facing headwinds in the form of state-sanctioned exemptions from federal challenges, budgets that are not keeping up with transaction volume, and the difficulty of showing why one specific acquisition satisfies the legal standard of "lessening competition" in the wake of so many deals that have already closed (such accretive acquisition has stymied investigations and challenges of physician consolidation, for example; Capps, Dranove, and Ody 2017).

Some—including an author of this proposal—have also raised concerns that the enforcement agencies overlook "cross-market" transactions that are not strictly horizontal, as defined above, but that nevertheless reduce competition and yield higher postmerger provider prices. Studies show that hospitals' acquisitions of other hospitals located in different geographic markets are also followed (on average) by large price increases and that acquiring hospitals tend to raise prices when their targets are located in the same state even if the acquirers and targets do not compete for patients in the same geographic area (Dafny, Ho, and Lee 2019). In a nutshell, the agencies' merger enforcement vis-à-vis providers, while successful, is narrowly focused. In recent years, hospital systems have vigorously expanded their geographic footprints, and if the patterns observed in previous years continue, this activity will yield further increases in prices.

Antitrust enforcement of statutes prohibiting anticompetitive conduct (e.g., monopolization and exclusionary practices) by dominant provider systems has accelerated in recent years. Two recent examples are the 2018 challenge of Sutter

Health's practices by the California Attorney (Becerra 2019) and the 2016 complaint by U.S. Department of Justice against contracting practices by Carolinas Healthcare System (United States District Court for the Western District of North Carolina Charlotte Division 2018). It remains imperative for enforcers to investigate such conduct and to pursue challenges where appropriate. These efforts are particularly important because some provider practices, such as requiring "all or nothing" negotiations whereby insurers cannot elect to contract with only selected system members, are becoming a greater impediment to competition as provider organizations grow.

In sum, while pro-competitive strategies are certainly part of the armamentarium to combat high health-care prices, they are greatly limited in terms of their ability to contain the effects of existing market power. Even robust market-based reforms (such as prohibiting "all or nothing" contracts by hospital systems or banning "anti-steering" clauses that interfere with insurers' efforts to vary cost-sharing across providers or sites of service) can have only limited impact in markets with limited competitive rivalry. Moreover, some markets (e.g., rural areas) may not be able to support enough providers to be competitive. We suggest an approach that allows pro-competitive strategies—and market forces more generally—to work when they can, but does not rely exclusively on them to contain price growth.

PRICES SHOULD BE FLEXIBLE SO THAT THEY CAN ADJUST TO CHANGES IN SUPPLY OR DEMAND AND TO INDUSTRY SHOCKS

Any effort to set or cap prices faces significant challenges. For one, we need multiple prices for the "same" service because the cost of delivering that service can vary widely depending on who is receiving it. A hip replacement for a patient with multiple health problems will involve additional costs relative to the same procedure for an uncomplicated patient. If prices do not reflect such variations across patients, providers may avoid the patients who are costliest to treat. These patients may be those most in need of treatment. Second, ideally prices would be able to be adjusted to reflect the quality of the services (or, better, the outcomes) delivered. Of course, quality is incredibly hard to measure and therefore hard to reward, but it is essential to try to reduce the incentive for providers to react to price regulation by skimping on quality of service. Third, prices would ideally adjust to reflect changes in the definitions of the unit of service. Relative to mature, stable industries, health-care delivery experiences frequent technological changes, necessitating frequent adjustments of service definitions. Relatedly, prices should change to reflect changes in productivity. For instance, as medical innovation makes some treatments more efficient, prices should fall to reflect this—but often they don't.

HIGH PRICES SHOULD BE LOWERED AND PRICE GROWTH CURBED WHILE ALLOWING MARKET FORCES TO ACT

Given the challenges associated with setting prices as well as the problems with relying fully on market-based prices, one potentially promising avenue is to combine the strengths of each in a hybrid approach that utilizes the market but places regulatory constraints on high prices and high price growth.

Capping prices can reduce the impact of provider market power while allowing prices to remain flexible beneath the cap. Capping price growth ensures that prices can rise to reflect a changing economy, but not at runaway speed. Most importantly, regulation that prevents pricing excesses but leaves the vast majority of prices untouched preserves room for pro-competitive strategies and market forces to propel prices closer to competitive market levels.

The Proposal

We propose a set of regulations to curb the harms associated with market failures in provider markets, without abandoning all the potential benefits of market-determined prices. Our package of reforms can be viewed as a fail-safe mechanism to restrain the largest pricing outliers while allowing market forces to influence prices in the vast majority of cases. As such, it can be implemented in the current health-care environment and is compatible with concurrent or future pro-competitive reforms.

In a nutshell, we recommend a three-pronged approach that includes the following:

- 1. Local market- and service-specific price caps that bind at the very top of the commercial price distribution.
- 2. Service-, insurer-, and provider-specific price growth caps that constrain price inflation.
- 3. Flexible oversight by state and/or federal authorities to address potential circumvention.

Below, we flesh out the details of each prong. We first present a summary of our preferred versions. We then discuss the rationale and key trade-offs inherent in each recommendation in greater detail, beginning with our strong preference to cap prices rather than set them. We discuss how caps can be

designed to prevent pricing excesses while allowing market forces to act, and then we turn to the benefits of capping price growth in addition to price levels. We conclude by discussing implementation requirements.

DETAILED SUMMARY OF OUR PROPOSAL

- 1. *Set rate caps to limit prices for health-care services at the very top of the entire (INN and OON) commercial price distribution. Caps would vary across geographic markets and would be set using data on prevailing commercial prices in each market. Specifically, we propose setting the cap equal to five times the 20th percentile of the commercial price distribution in a given market. For example, the price of an MRI on an injured knee in the Washington, DC metro area would be capped at 5 times the 20th percentile of prices for that service in the area.*

Rationale: Existing evidence suggests that some commercial prices are excessive. “Cadillac” caps can address the most egregiously high prices immediately. While publicity around surprise billing has emphasized OON prices, we favor capping both INN and OON prices for two reasons. First, only a small share of spending is OON (see table 1), so caps limited to OON prices would have an immediate, direct impact on only a small fraction of total spending (e.g., approximately 1.8 percent of commercial inpatient facility spending). Second,

TABLE 1.
In-Network versus Out-of-Network Spending Shares by Type of Charge and Care Setting

	Facility		Professional	
	Inpatient (percent)	Outpatient (percent)	Inpatient (percent)	Outpatient (percent)
Network status				
In-network	97.5	93.4	85.7	87.7
Out-of-network	1.8	4.8	8.8	8.4
Unknown	0.7	1.7	5.5	3.9
Share of total spending				
	24.3	32.1	5.2	38.4

Source: Health Care Cost Institute 2019; authors’ calculations.
Note: Data are for 2017. The sample consists of 41.9 million individuals with group-sponsored commercial insurance aged 0–64.

any indirect impact of OON caps on INN prices will depend on a large set of factors subject to much uncertainty. The spillover from OON to INN prices could be small and take years to be realized.

To retain (and perhaps amplify) the ability of markets to allocate resources appropriately, we favor allowing market-specific price variation through market-specific caps based on a percentile of the commercial price distribution in each market, rather than based on a public fee schedule like the one used by Medicare. We favor a multiple of the 20th percentile (subject to an upper limit in unusual markets) of market prices for a given service because prices vary less within lower percentiles than within higher percentiles and data errors are less likely in the 20th percentile than in lower percentiles. However, because of potential data errors and lumpiness in markets with few providers, we believe that further restrictions are needed. Specifically, we suggest top-coding these caps at the 75th percentile of the distribution of 20th percentile market-specific prices in order to avoid basing caps on outliers.² We favor basing caps on market-wide prices as opposed to insurer-specific prices; if the latter are utilized, policymakers risk exacerbating the advantage that insurers with large market shares have over smaller competitors.

Using a large sample of commercial claims, we estimate that for office visits the median 20th percentile commercial price approximates the Medicare price and that across inpatient

services the median 20th percentile commercial price averages about a third more than Medicare. Medicare prices are set to rise very slowly in the future under current law. For example, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician fees are scheduled to rise less than inflation for decades, and facility fees under the Patient Protection and Affordable Care Act (ACA) are set to rise less than input costs due to productivity adjustments. By using a multiple of a private price, we allow for more realistic fee growth and avoid directly linking private rates to Medicare policies.

Table 2 presents estimates of the impact of capping commercial inpatient facility spending at five times the market- and service-specific 20th percentile price, as estimated from a sample of roughly 42 million commercially insured enrollees in 2017, accounting for about one-quarter of the commercially insured population under age 65. We estimate the proposed caps would directly affect 4.5 percent of inpatient admissions, 84.3 percent of providers, and 89.3 percent of markets and would save 8.7 percent of inpatient spending.³ Importantly, the specific multiple of the 20th percentile price can be adjusted to fit stakeholder preferences, based on the savings target and distributional concerns. For the sake of comparison, table 2 also provides estimates of the impact of two alternative caps for inpatient facility prices: twice the market-service median price, and the 90th percentile of this price distribution. Relative to the proposed

TABLE 2.

Estimated Savings from Inpatient Facility Spending under Our Proposal by Network Status

Market-service price percentile cap	Censored?	Multiple	Savings (percent)	MSAs affected (percent)	Providers affected (percent)	Cases (admissions) affected (percent)	Services affected (percent)
All prices							
20th	75th	5	8.7	89.3	84.3	4.5	88.8
50th	75th	2	13.2	98.6	93.5	9.2	97.0
90th	No	1	8.2	99.5	95.3	11.7	98.3
OON only							
20th	75th	5	1.1	33.2	11.3	0.4	43.2
50th	75th	2	1.2	46.7	16.5	0.5	54.4
90th	No	1	1.0	58.0	19.5	0.3	58.1
OON spillover							
20th	75th	5	2.1	89.3	84.3	4.5	88.8
50th	75th	2	3.3	98.6	93.5	9.2	97.0
90th	No	1	3.1	99.5	95.3	11.7	98.3

Source: Health Care Cost Institute 2019; authors' calculations.

Note: Data are for 2017. Percentages are out of inpatient facility sample (e.g., savings are savings from inpatient facility spending only, not overall spending). The sample consists of 41.9 million individuals with group-sponsored commercial insurance aged 0–64, 0.9 million of whom had 1.1 million inpatient admissions that year. OON spillover simulations assume that INN prices for which OON cap binds are reduced by 10 percent. Estimates assume no other behavioral changes. Provider revenue affected is only revenue from claims submitted to one of the insurers in the Health Care Cost Institute data, not total provider revenue. Services are diagnosis-related groups (DRGs). The bolded row denotes the preferred proposal parameters. MSAs are metropolitan statistical areas.

benchmark (20th percentile) and multiple (5), savings from the median times two cap are significantly larger (13.2 percent), and savings from the 90th percentile cap are similar (8.2 percent).

In sum, we propose to cap negotiated provider prices at five times the market-wide 20th percentile service price (or the 75th percentile of such service-market price percentiles nationally, if that is lower). We recognize that the effect of this proposal is much smaller than the effect of proposals that cap fees at 150 or 200 percent of Medicare fees (e.g., the latter would reduce inpatient facility spending by 26.0 percent in our sample). While policymakers may opt to lower the multiple for the caps we propose and thereby increase projected savings, we believe our approach (i.e., caps based on private prices and not Medicare prices) and our choice of multiple would be less disruptive and would pose a smaller risk of adverse effects on access and quality. In addition, higher caps allow the market “room to work,” which may be particularly valuable if pro-competitive reforms are implemented.

2. Annual service-, insurer-, and provider-specific price growth caps would be indexed to economic growth and vary inversely with provider price.

Rationale: Placing a cap on price growth, as opposed to only limiting prices at the upper end, can constrain pricing of all providers for all services. As long as the constraint is not severe, this approach is beneficial because it ensures that no service price grows at runaway speed. Tethering growth to an index of prices (e.g., the Consumer Price Index [CPI] plus a grace factor) can place an upper limit on overall price growth that price caps on levels cannot accomplish. We suggest a grace factor of 1 to 2 percent, which can be adjusted to meet policymakers’ preferences. Rhode Island’s experience with price growth caps based on insurer-hospital contract review suggests that such caps can be effective and feasibly implemented (Baum et al. 2019; see box 1). Price

growth caps should be specific to each insurer-provider-service combination, so that a contract or service that is not growing cannot mask others that are growing rapidly. We also propose that the growth cap vary inversely with current provider price levels, but without completely erasing price differentials across providers. Tethering growth cap generosity inversely to provider price—that is, setting a lower growth rate cap for providers with higher price levels—avoids penalizing currently low-price providers (who, all else equal, are more efficient). Lower growth rate caps incentivize high-price providers to become more efficient. Over time, tethered caps will likely induce greater convergence of prices across providers, up to a point. Preserving the possibility of some variation makes it possible for markets to reward higher performance.

3. Flexible oversight by federal and/or state agencies would be triggered when growth in per-capita commercial medical expenditures or commercial insurance premiums exceeds a predetermined threshold.

Rationale: Gaming is a possibility, particularly given the complexities of alternate payment models. Because of the potential for providers to circumvent price caps (e.g., by charging infrastructure fees or changing the definition of a service), some review at the aggregate spending or premium level will be needed to ensure that market power is not being realized via payments outside of the fee-for-service system. Such review would be triggered by total medical expenses or insurance premium growth rising above predetermined thresholds.⁴ Any premium-related triggers would consider changes in benefit design; that is, they would be based on growth in premiums, holding actuarial value constant.⁵

While the federal government’s role is important, especially with respect to data gathering and Employee Retirement Income Security Act (ERISA) preemptions (discussed below), we envision that states will be heavily engaged in

BOX 1.

Price Growth Caps in Action: Rhode Island Sets an Example

Rhode Island uses hospital price growth caps based on insurer-hospital contract review: Insurers are barred from accepting hospital contracts with price increases exceeding the increase in the federal Consumer Price Index for All Urban Consumers (CPI-U) plus a certain percentage, which started at 1 percent in 2015 and was set to decrease annually to 0 percent in 2018 (Reger 2016). One recent study (Baum et al. 2019) attributed an 8.1 percent reduction in fee-for-service spending over the period from 2010 to 2016 to Rhode Island’s 2009 enactment of price growth caps as part of the state’s regulations to slow health-care spending growth. Given that Rhode Island adopted additional reforms as part of its 2009 regulations, its growth caps are likely responsible only for part of this reduction. However, Rhode Island’s experience with price growth caps based on insurer-hospital contract review suggests that such caps can be effective and are feasible to implement.

enforcing the laws, given their local expertise and existing infrastructure.⁶ While states will likely need to invest in additional capabilities, a great deal of the necessary expertise exists in state departments of insurance and of health and human services. Officials in these agencies would monitor data on expenditures and premiums to identify if a trigger point is reached, and if that occurs, they would engage in remedies available to them or made available through new statutes. Remedies may include requiring the contracting parties to revisit negotiated payment rates or to implement other methods to ensure compliance with price and price growth caps. Officials may target contracts that contribute substantially to excessive spending growth (e.g., as the Massachusetts Health Policy Commission is authorized to do). The key principles are that the regulator must have flexibility but also the power to compel providers to accept lower prices or to lower non-price payments. However, we are not in favor of prohibiting payments outside of the regulated fee schedule altogether because such an approach could slow innovation in care delivery.

Last, we recommend a mechanism for periodic review and update of regulations. This process would solicit stakeholder feedback, address concerns, and measure market response; a model is the process by which the Centers for Medicare & Medicaid Services (CMS) proposes regulations, receives and responds to comments, and issues final rules. These processes will help to ensure that regulations can be adapted to optimize market function and minimize unintended consequences.

PRICES SHOULD BE CAPPED RATHER THAN SET TO ALLOW ROOM FOR MARKET FORCES

We propose setting rate caps to limit prices for health-care services at the very top of the entire (INN and OON) commercial price distribution. Caps would vary across markets and would be set using data on prevailing commercial prices in each market. Specifically, we propose setting the cap equal to five times the 20th percentile of the commercial price distribution in a given market.

An alternative approach we did not recommend is to set rates in the commercial market, as Medicare does for its beneficiaries in the public market. The primary challenge with this approach is assessing what the appropriate price should be for each service, as discussed above. A secondary challenge is the fact that new price schedules would imply enormous adjustment costs in light of the existing variation in commercial prices. Moreover, a set price schedule would likely entail large cuts for some providers and increases for other providers. The cuts could affect employment, access, and potentially quality in ways that are difficult to predict and potentially undesirable, and the increases would reduce fiscal savings and may confer the advantages of market power to

providers that currently lack such power. For these reasons, we do not propose rate setting as the basis of regulation.

Another form of regulation that we considered, but ultimately lean against, is setting the values for rate caps directly (rather than pegging them to the actual distribution of market prices). In either case, capping rates has the advantage of allowing market forces to generate prices beneath the cap, while ensuring that a maximum price is not exceeded. To harness the pro-competitive benefits of rate caps and to minimize market disruption, we favor rate caps that are based on the distribution of prevailing provider prices and that affect only the very highest prices in a market.

A Cap on All Prices, Rather Than a Cap on Out-of-Network Prices Only, Enables Savings to Be Realized

A key consideration for provider price regulation is whether it should apply to (1) all prices, (2) prices for services provided by OON providers only, or (3) prices for services provided by OON providers delivered in INN facilities (i.e., surprise bills). We focus on the first two options, as the latter option is already under consideration by Congress and represents the smallest share of spending.⁷

In developing our recommendation, we evaluated not only the direct effects of regulating the different categories of prices (table 1 shows spending shares by network status), but also the indirect effects of the respective options on insurer-provider negotiations. We focus on these indirect effects here.

Regulating only OON prices has the advantage of being the least intrusive approach with respect to negotiations between plans and providers. Plans and providers may come to any agreement they want with respect to INN prices.

Yet OON-only regulation has several disadvantages. The most obvious is that OON spending is a small share of total spending (table 1), and in some cases the INN price may be higher if providers with market power can demand not only high prices but also INN status.

The aforementioned problem may not be severe, because regulating OON prices will indirectly affect INN prices. If OON prices are regulated, providers may be less inclined to stay OON, which would give insurers additional negotiating leverage that could translate into lower INN provider prices. In the extreme, the OON price would effectively cap the INN price because providers, knowing that they would only get the OON price if they stayed OON, may feel compelled to accept INN prices very close to the OON cap. This dynamic seems to occur in the Medicare Advantage program, where CMS limits OON prices to the Medicare price and the INN prices approximate Medicare prices even though the same insurers pay providers more in the commercial market (Berenson et al. 2015; Chen, Hicks, and Chernew 2018). It is not clear that this

result would translate to the commercial market, however, because the OON option for providers is different. If a Medicare patient opts out of Medicare Advantage, the patient is still enrolled in traditional Medicare and the provider will earn the Medicare rates. That is not the case in commercial markets, where there is no backstop subsidized plan paying low rates.

INN providers in commercial markets may be able to charge rates above OON limits if they are very important for insurers to bring into their network. In principle, insurers could minimize the financial consequences for patients if their preferred provider stayed OON by offering generous OON coverage. But if OON providers can limit access for an insurer's patients through nonfinancial means (e.g., through long waiting times), this conduct may effectively force insurers to bring them INN at rates above the OON limit. Thus, the ultimate impact of an OON-only limit on INN prices may hinge on the current ability of providers to command prices above the limit, which may depend on whether being INN improves beneficiary access (by reducing waiting times, for example) and on the degree of coordination and cooperation with insurers. Existing evidence does not provide clear answers about how this would play out. Regulating all prices (i.e., OON and INN) solves this problem by addressing market power across both OON and INN settings.

The extent to which regulated OON prices spill over to INN prices is thus uncertain, but it is crucial in determining the potential savings from OON-only regulation and consequently in deciding between OON-only and all-price regulation. With this word of caution in mind, we simulated three scenarios under our proposal (table 2). First, assuming OON-only regulation and no spillovers would save 1.1 percent of inpatient facility spending. Second, regulating OON and INN prices would save 8.7 percent. Note that OON-only regulation with complete spillovers would save the same amount but may be unrealistic. Lastly, if we assume that OON-only regulation has a small spillover effect, specifically that it would cause INN prices that are above the OON cap to fall by 10 percent, we estimate savings of 2.1 percent.

Because of the uncertainty of any spillover and because our recommended price caps are high enough that they likely limit prices primarily where significant market power is being exercised, we opted for capping both OON and INN prices.

Price Caps Should Be Based on Prevailing Commercial Prices, Not on Medicare Rates

The simplest strategy for regulating commercial prices (whether by a fixed rate or, as we propose, a cap) would be to use a multiple of Medicare rates, which are intended to reflect the average costs of providing care. While Medicare has been able to use its market power to set considerably lower

prices than those that have arisen in the commercial sector, it has faced challenges in accurately determining relative prices. Indexing commercial rates to Medicare rates adopts Medicare's relative prices and all of their known distortions, which reflect imperfections in measuring cost and quality as well as political forces.

One concern is that Medicare prices may not be appropriate in the commercial sector. For example, Medicare fees are based on the estimated cost of serving Medicare patients. Costs for commercial patients, generally younger and with fewer co-occurring medical conditions, may differ, particularly for services not commonly delivered to Medicare beneficiaries, such as labor and delivery services. Institutional differences further complicate use of Medicare prices. For example, Medicare payment schedules for outpatient facility services substantially differ from rules used by commercial insurers, even for the same services.⁸

A related concern is that Medicare prices reflect political forces that may lead to distortions in relative prices. For example, physician services are based on recommendations from the Relative Value Scale Update Committee (RUC), an American Medical Association committee of physician specialty society representatives. The RUC process has led to overpayment for some services and underpayment for others. Medical specialties that provide common services tend to vote together, leading to higher prices for specialties with greater representation (Chan and Dickstein 2018). In part because specialist physicians outnumber primary care physicians on the RUC, specialist services tend to have higher prices than primary care services (Bodenheimer, Berenson, and Rudolf 2007). This over- and underpayment not only directs care to some services and away from others but also influences the health-care workforce distribution. While it is true that commercial prices often mimic these distortions, the commercial market can, and in some cases does, do better. For instance, commercial prices for laboratory services and durable medical equipment have been shown to be lower than traditional Medicare prices, reflecting a correction in the commercial market for services for which Medicare overpays (Trish et al. 2017).

The problem of setting appropriate caps is complicated by changes over time, as production costs for particular services may change. In a well-functioning market, a reduced cost of production would lead to lower prices, but this process is slow in public systems. An illustrative example is cataract surgery, which technology has allowed to be performed in less than 15 minutes since at least the early 2000s but—despite several rate cuts—still is reimbursed at almost five times the rate of cognitive services such as evaluation and management visits because the rate-determining time estimates are based on out-of-date procedure lengths (Centers for Medicare &

Medicaid Services 2018; Sinsky and Dugdale 2013). While imperfection in Medicare prices may be less of a concern when these prices are used as a cap (rather than when setting rates), the imperfections are still cause for concern.

A final, core concern is that if commercial prices are tied to Medicare prices, they will reflect numerous policy decisions that policymakers might not want to spill over to the entire health-care system. For example, MACRA calls for essentially flat physician fees for many years, and ACA productivity adjustments require some fees to rise at rates below inflation in input prices. These policies may support Medicare's fiscal position, but it might not be reasonable to impose them on the entire system. Any future Medicare fee cuts to address broader budget concerns will also be transmitted to the whole system, which may lead to unintended consequences and complicate the Medicare debate. Finally, to the extent that Medicare prices are transmitted (with a multiplier) to the commercial sector, there will be greater political pressure to raise Medicare prices, causing program expenditures to rise.

We favor basing price caps on a multiple of some percentile of the price distribution for a given service in a given market. We believe five times the 20th percentile price is a reasonable selection, but the specific point to use can be adjusted based on stakeholder input and policymaker objectives.

We recognize that commercial prices come with their own set of known distortions that are important to anticipate. First, while commercial payers can use their clout and agility to pay lower rates than Medicare in some settings and for some services, they are also more vulnerable to the market power of suppliers. As providers have consolidated, they have negotiated ever-increasing prices that are well above the Medicare rate for the vast majority of health-care services (Cooper et al. 2019).

Researchers have also documented substantial heterogeneity in prices for the same service within well-defined markets, a sign that markets are functioning poorly. For instance, prices for lower limb MRI ranged from about \$500 to \$3,000 in Philadelphia, PA, when averaged over the period from 2008 to 2011 (Cooper et al. 2019). Much of that variation reflects provider market power.

Second, commercial prices also reflect insurer market power. Recent research shows that insurer market share is inversely correlated with service prices within provider groups. One estimate suggests that insurers with market shares of 15 percent or more negotiated office visit prices that were 21 percent lower than those negotiated by insurers with market shares under 5 percent from the same provider groups (Roberts, Chernew, and McWilliams 2017). Other studies show that commercial prices track Medicare prices more

closely in areas with concentrated insurers and competitive physician markets (Clemens and Gottlieb 2016).

Third, commercial prices are often based on a (contract-specific) multiple of Medicare prices. As a result, many distortions of relative prices arising in Medicare are likely transmitted to and amplified in the commercial sector. In fact, a \$1.00 increase in Medicare prices leads to an estimated \$1.16 increase in corresponding commercial prices, on average (Clemens and Gottlieb 2016). However, utilizing Medicare's price rubric does not rule out the possibility that private markets may still be doing a better job of getting some prices right, as exemplified by the evidence on laboratory services and durable medical equipment noted above.

Despite the caveats expressed above, prevailing commercial prices, although imperfect, make a better basis for price caps than do Medicare fee schedules. Specifically, commercial prices are more flexible over time and avoid tying all fees to Medicare rates, which, at baseline, are set to rise below inflation indefinitely. Further, basing caps on commercial prices reflects the relevant service and patient mix as well as the applicable payment rules, and allows for prices to more easily adjust for productivity gains (e.g., through improved medical technology). Finally, we believe the concerns listed above, which largely relate to market power, can be mitigated by setting caps at a multiple of low points on the distribution of commercial prices.

Basing Price Caps on a Multiple of a Low Percentile of the Prevailing Price Distribution Is Preferable to Using a High Percentile

We propose to set price caps at five times the 20th percentile market- and service-specific price. We prefer a higher multiple of a lower price percentile over a lower multiple of a high price percentile.

Because of the distortions in commercial provider prices discussed above, setting rates based on prevailing commercial rates would cement current imperfections and market failures. However, rate caps circumvent these issues by allowing price negotiations to proceed under the cap, while placing downward pressure on prices. Since higher percentiles of commercial prices in a market (or even the median in a concentrated market) can reflect substantial provider market power, we prefer using a multiple of a lower percentile (specifically, five times the 20th percentile). A lower percentile will be less distorted by market power, and its variation across markets may be a closer reflection of the variation in the cost of efficiently producing an acceptable quality of care across markets. The multiple allows room to provide higher quality (which may entail higher cost) and allows for providers who have higher production costs for reasons that are difficult to quantify or to observe.

A CAP ON PRICE GROWTH ENSURES THAT NO PROVIDER OR SERVICE PRICE INCREASES EXCESSIVELY

We propose annual service-, insurer-, and provider-specific price growth caps indexed to economic growth that vary inversely with provider price.

One challenge with rate caps is the possibility of significant exercise of market power under the cap. Capping price growth can limit this concern by restraining providers at all points in the price distribution. Specifically, unlike rate caps, which may affect only some providers and their services, growth caps affect all providers but do not cause any to see an absolute decline in prices. As a result, growth caps can be less disruptive and allow negotiation and other market mechanisms to proceed. We therefore suggest growth caps as the second prong of our proposal.

Price growth caps can be designed in a number of ways; the exact design and parameters can be customized according to stakeholder needs. For instance, regulators may want to ensure that overall health-care spending does not exceed a target level, which may imply a specific price growth cap given assumptions on service quantity growth. Providers will want to ensure that the growth cap leaves room to respond to market shifts (e.g., to invest in new technologies) and to invest in quality improvements.

Any growth index utilized should not be based exclusively on measures of health-care prices (e.g., the CPI for medical care; see Bureau of Labor Statistics 2019), as the goal of regulation is partly to constrain spending growth to something lower than historical levels. Instead, the index should reflect price growth for a more inclusive basket of goods and services or a more general measure of economic growth. Options include, among others, the CPI or gross domestic or state product. If stakeholders are concerned that basing the index on general economic indicators is too restrictive, an adjustment factor can be added (e.g., CPI plus 1 percent). Alternatively, the index could incorporate health-care-specific factors such as wage growth for health-care personnel.

Adjusting Growth Caps to Vary Inversely with Provider Price Can Focus Regulation on the Highest-Price Providers

We recommend that price growth caps vary inversely with provider-service price to exert more downward pressure on high-price providers.

To the extent that the substantial heterogeneity in prices today reflects market failures or market power rather than quality—and research suggests that it does (Cooper et al. 2019; Gaynor, Ho, and Town 2015)—then growth caps can be a function of provider features and their location in the price distribution. For example, growth caps can be made more stringent for providers with higher baseline prices within

their market, leading to some convergence of high- and low-price providers.⁹

To increase the convergence in prices across different providers, the growth cap can be adjusted up or down based on each provider's price level, in such a way that weighted average price growth approximately equals the combined target for price growth. We do not believe convergence should be so extreme that it equalizes all prices, because quality or case-mix differences that necessitate some price variation may be unaddressed by service definitions. Yet, up to a point, convergence will yield more reasonable relative prices across providers, keeping in check the influence of provider market power on prices.

FLEXIBLE REGULATORY OVERSIGHT IS NEEDED TO ENFORCE THE INTENT OF THE REGULATION

We propose flexible oversight by federal and/or state agencies, triggered when growth in per-capita commercial medical expenditures or commercial insurance premiums exceeds a predetermined threshold.

Data

Requirements

Price regulation based on prevailing commercial rates requires the periodic collection and analysis of health-care transaction data. Existing large-scale commercial claims databases such as the IBM MarketScan and Health Care Cost Institute databases (Health Care Cost Institute 2020; IBM 2020) are routinely used in research and can be starting points for exploring the potential impact of our proposal. Implementation of the proposal, however, will require mechanisms for compelling payers to transmit either a census or a sample of claims data to state or federal all-payer claims databases (APCDs). This transmission is important to give implementing authorities timely access to complete (or at least representative) information on prices. As of early 2019, 20 states have implemented or are in the process of implementing statewide APCDs (APCD Council n.d.). While some of these states have tasked their department of insurance, department of public health, or other existing agencies with the administration of these databases, at least five states¹⁰ have established new agencies specifically for this purpose. The biggest challenge in building comprehensive health-care price databases has come in the form of a Supreme Court decision holding that the participation of self-insured groups in APCDs is voluntary.¹¹ As a result, some groups have stopped participating. To enable states to build comprehensive APCDs that can serve as a more solid foundation for health-care price regulation efforts, federal legislation mandating reporting by all payers would likely be needed.

Data Noise

A major concern with basing price caps on *market-specific* distributions of prevailing commercial rates is that recorded transaction prices may contain data noise, that is, data errors or outliers. Data errors include data processing mistakes, refunds that may appear as negative charges in transaction databases, and payments outside the fee-for-service system (such as per-member-per-month fees) that appear as charges with unusual amounts. Data analysts can deal with most of these errors. However, data noise due to outliers, such as markets with fluctuation in prices due to a small number of providers or services provided (as happens in some rural markets), is more difficult to correct. One solution would be to use a national summary (e.g., median) of the distribution of commercial market-service price percentiles (e.g., the 20th percentile price in each market for each service), but this approach would fail to accommodate market differences in input costs without further adjustment (e.g., using Medicare geographic adjusters); moreover, it would eliminate much of the local market information that may be reflected in commercial prices. We navigate this trade-off between robustness and noise and allow for market-specific variation by capping the 20th percentile market-service price caps at the 75th percentile nationally. For rare services that simply would not have enough data observations in any given market, however, it may be advantageous to use a multiple of the input-cost-adjusted national 20th percentile price.

Enforcement

State regulators would monitor data on medical expenditures and premiums to identify if a trigger point is reached, and if that occurs, they would engage in remedies available to them or made available through new statutes.

Locus of Regulation

To implement our proposal, regulators will need expanded authority to acquire data from and to regulate both health-care payers and providers. While it is more convenient to obtain data from payers, it is likely preferable to enforce the rate and rate growth caps through direct regulation of providers, particularly if our proposal is enforced at the state level. ERISA preempts state regulation of self-insured health plans, but, according to Supreme Court precedent, not of providers paid by such plans.¹² Thus, it is possible to implement our proposal through either state or federal legislation that directly regulates providers.

Payer compliance with price regulations may be most naturally overseen by state departments of insurance. While the extent of enforcement mechanisms available to these departments varies by state, in at least some states the department of insurance regulates private contractual agreements governing health-care prices. In 2011, the Rhode

Island Superior Court ruled that the Rhode Island Office of the Health Insurance Commissioner acted lawfully in assessing an administrative penalty and ordering corrective action when it found that the financial terms of a contract between Blue Cross of Rhode Island, a not-for-profit insurer, and a local health-care delivery system unreasonably favored the delivery system and threatened Blue Cross's solvency. The health insurance commissioner's office was given broad duties to monitor and intervene in the "financial state and methods of doing business"—including setting reimbursement rates—of every nonprofit payer in the state. In states without the desire or means to regulate private insurance contracts, the department of insurance or state secretary of health and human services could monitor growth in total medical expense or insurance premiums in aggregate and employ strategies such as stakeholder meetings or public hearings if growth exceeds a specified target.

Regulations targeting providers may be implemented and enforced through the licensing and regulation powers of state departments of health. Such regulations may operate on inpatient facilities, outpatient facilities, provider practices, or individual providers. While CMS would be positioned to facilitate implementation efforts by offering federal guidance and start-up grants, state departments of health need not wait for federal action to start building infrastructure. Importantly, the extent and form of infrastructure can be customized to state needs.

Provider Capture of Regulators

Providers, as large employers delivering an essential service to local residents, typically enjoy strong relationships with regulators. These relationships can obviously lead to a weakening of regulation, as well as to insufficient monitoring and enforcement. We believe providers should have a mechanism to register concerns and to contribute their experience with new regulations, particularly regarding the effect on access or quality of care. However, regulation also needs to be designed to avoid regulatory capture by providers. This aim can be achieved through both substance and process. Substantively, regulation based on a distribution of commercial rates minimizes the direct channel by which providers could influence caps by pressuring regulators. In terms of the process, regulatory oversight requires sufficient enforcement mechanisms, including moral suasion (i.e., public shaming), review, and the potential for financial penalties.

Unintended Consequences

Lower prices in the commercial sector will pressure providers to deliver care more efficiently. While this is clearly a positive outcome, it could imply lower employment or wages across the entire sector since labor expenses represent the largest share

of health-care expenses. One analysis of Medicare inpatient hospital price changes from 1996 to 2009 suggests that nonprofit hospitals offset about 90 percent of lost revenues by reducing operating expenses, mainly by saving on personnel

costs (White and Wu 2014). To minimize the potential impact from unintended consequences such as these, our proposal combines price caps that apply directly to only the highest commercial prices in a given market with price growth caps that prevent excess growth while allowing prices to adjust and keep pace with economic changes.

Questions and Concerns

1. Would this proposal threaten provider viability?

Depending on the specifics of regulation, some providers will face a price decrease for some services. This may induce providers to become more efficient, but some of the pressure will be absorbed by decreased profit above what would be needed to secure provider services. Depending on their service mix and cost structure with respect to others in their market, some providers may face a steeper decline in revenue than others. Our proposal mitigates threats to provider viability in two ways. First, the price caps are set at a high level (five times that received by others in the market), leaving most providers unaffected for most services. Second, our cap on growth places the challenge of containing costs (again, for most services and providers) primarily in the future, so that providers can plan for it.

2. What impact, if any, would price regulation have on the quality of care delivered?

Since prices are capped only at the very top of the distribution and growth is capped at reasonable levels, our proposal will affect only a minority of services for most providers. Given evidence that commercial prices are very high and variable, and that quality of care is weakly (at best) correlated with price, we do not have reason to believe that our proposal would significantly diminish the quality of care, at least in the long run. Our proposal does not change incentives for health-care delivery reform nor incentives to innovate.

3. Why not set expenditure caps (e.g., on a per-person-per-month, risk-adjusted basis)?

Expenditure caps are conceptually appealing, but are hard to implement for a number of reasons. First, an expenditure cap could only be enforced at the insurer level, which would necessitate federal legislation as states cannot currently regulate self-insured plans. Second, it is difficult to determine the correct quantity that would be subject to an expenditure cap and difficult for insurers to comply. Ideally, the cap would apply to expenditures per insured person, holding plan design and risk of the insured constant. Such a measure will fluctuate with enrollment swings in a way that could be challenging for certain insurers—particularly smaller insurers—to navigate. In addition, it is difficult to project what total expenditures will be in any year, for reasons ranging from illness (e.g., flu

season) to changes in provider practice. Third, regulating premiums does not directly assist insurers in bringing down the highest provider prices. An expenditure or premium cap without any authority over prices paid to providers may be difficult to meet. To comply, many insurers will turn to more cost sharing, which (if adjustment for plan design is complete) lowers net spending through volume reductions. Prior research shows that reductions in service utilization induced by cost sharing are not optimal (Brot-Goldberg et al. 2017).

We propose to use premiums or total medical expenditure as a flag to trigger regulatory review, but we do not recommend relying on this crude measure to enforce a hard ceiling on spending for a given provider or contract. Importantly, research has shown that provider prices are a main driver of high health-care spending and that pro-competitive reforms have not done enough to constrain them. We thus favor addressing prices directly.

4. How does this proposal deal with alternative payment models?

The existence of alternative payment models (APMs)—under which some providers are currently paid and which will evolve over time—poses additional challenges to regulation by introducing another layer of complexity. Since APMs can have highly heterogeneous payment schemes, it is essentially impossible to adjust for all of them.

For instance, it is very challenging to regulate episode-based payments. There are many ways to define episodes in terms of episode triggers, included services, and episode length. This heterogeneity extends to the incentive layer, including variation in shared savings percentages, downside risk, and quality bonuses. Moreover, no uniform target of episode-based regulation exists since the residual claimant (the entity responsible for the residual risk after accounting for all services included in the episode) varies by care model.

One sort of APM is more amenable to direct regulation: population-based payment, as used in accountable care organization programs. One could cap risk-adjusted, per-member-per-month spending (capping its level or rate of growth) and allow health-care systems to decide how to pay sub-units. This approach is essentially a version of

regulating total medical expenditure. However, the current use of population-based payment is limited (and could be discouraged if regulated).

Although we have opted not to regulate APMs, our approach does not impede APMs. We recognize that APMs can serve as a vehicle to circumvent regulation of fee-for-service prices, which motivates our triple-pronged proposal to cap prices, cap price growth, and establish flexible oversight.

5. Why not advocate for a public option as a means to constrain provider prices, rather than direct regulation of prices?

We propose a combination of (1) market- and service-specific provider price caps and (2) service-insurer-provider price growth caps. Because our price caps would affect only the highest-priced instances of a service in a market and growth caps do not reduce prices in absolute terms, our proposal minimizes disruption while constraining the exercise of market power that leads to high prices. We believe that, relative to a public option (Neuman et al. 2019), our proposal can reduce health-care prices with less disruption, fewer unintended consequences, and lower implementation costs. It is in this vein only (i.e., the impact on prices) that we contrast our proposal to a public option approach. We appreciate that a public option can serve other worthy policy goals such as expanding access.

Public option models have many different variants, but at their core, these proposals create a publicly run insurance plan that competes with private plans. Public option proposals vary in the rules that govern the prices paid to providers, but most are designed so that the public plan has access to prices below those prevailing in the commercial market. For example, the public option may pay 150 percent of Medicare rates and providers may be required to participate or lose the right to serve Medicare beneficiaries. In many proposals, access to the public option is limited to select groups (e.g., it may only be available in the individual market).

The existence of a public option plan could alter the nature of negotiations between commercial insurers and providers. Depending on how attractive the public option is to patients, insurers may face competitive pressure to negotiate lower provider prices, and providers may be willing to accept lower commercial rates to preserve the commercial market and avoid encouraging beneficiaries to shift into the public option. Thus, a sufficiently attractive public option may effectively lower commercial prices without the price caps, price growth caps, and enforcement we propose. That phenomenon seems to occur in the Medicare Advantage program, in which providers who do not contract with a Medicare Advantage plan are deemed OON and earn traditional Medicare rates.

One advantage of the public option model with regards to pricing is that enforcement to prevent gaming (the third prong of our proposal) may not be needed because the premium of the public option, set by the government, can act to constrain premiums and thus total medical expenses (of which prices are a key part). Moreover, a public option guarantees that savings are passed along to enrollees in the form of lower premiums, which is less certain in a price regulation approach in which insurers could retain savings.

However, a number of concerns about a public option approach lead us to favor the combination of price caps and price growth caps we propose.

Most importantly, public option approaches cannot avoid the issue of how provider prices are set. They need to either impose a fee schedule or build infrastructure to negotiate contracts with providers. Since the main appeal of a public option seems to be potential access to cheaper coverage for consumers, it is improbable that a public option plan would rely solely on negotiation absent price controls. Indeed, most existing public option proposals set provider prices as a function of existing public fee schedules (e.g., 150 percent of Medicare). Thus, prices currently below the public option price would rise, negating some of the savings from imposing lower prices. While it would be possible to allow a public option to set a cap and allow negotiation of rates below the cap, such a system would add complexity. To make it effective, the government would likely have to require providers to participate, but this approach may cause prices to fall well below the capped price, making it more unpredictable and disruptive than our proposal would be.

If provider participation in the public option is not universal, it could lead to *higher* provider prices in the residual commercial market if dominant providers are able to extract even higher prices from private insurers. This could happen if lost profits from the public option stimulate further consolidation of providers or if the consumers remaining in private health plans are less price sensitive than those enrolling in the public option.

An additional concern is how the existence of a public option affects the commercial insurance market. In the presence of a public option, the viability of commercial health plans will depend not only on whether they can negotiate competitive provider prices and offer desirable benefits, but also crucially on appropriate risk adjustment to avoid adverse selection. This may require additional government intervention into commercial insurance markets, and therefore more disruption.

Public option proposals are likely to be costly to implement. They may require new public infrastructure investments in order to create and administer health plans in many markets,

whereas the benefit of lower provider prices can be achieved without such investments under our proposal. Public option plans would also need to specify plan benefits. They may use existing public plans (e.g., the Federal Employees Health Benefits Program) as guides, but overall the process of setting benefits may be difficult and subject to political forces that could lead to suboptimal designs.

Finally, basing prices on existing public fee schedules both subjects the prices to the weaknesses of the policy process and may have deleterious effects on other administered price setting. For example, fees in existing public programs would likely rise as a result of stakeholder advocacy. As a case in point, Maryland's all-payer system has lower commercial prices but higher Medicare prices compared with those in similar states (Haber et al. 2018).

In sum, we believe that while a public option offers some benefits, it creates considerable uncertainty and risk. We believe that in regards to the goal of lowering prices, our approach offers more immediate relief, at lower cost, and with less uncertainty and potentially fewer unintended consequences.

6. How would benefits be passed through to consumers?

Our proposal focuses on the prices for health-care services. These services are paid by insurers, and it is important that the savings associated with our proposal be passed on to consumers. Several features of the health-care system will encourage savings to be passed on. These features include the medical loss ratio regulations that limit the extent to which premiums can exceed medical expenses. Self-insured employers, who cover a majority of working-age adults, have a fiduciary responsibility to pass on savings. Further, the regulatory framework that we consider includes a trigger based on total medical expense and premium growth that will help guide savings toward consumers.

Conclusion

Premium growth in the commercial health insurance market has generated significant concern. This growth has largely been driven by price increases. While strategies to address this problem by enhancing competition are possible, these strategies would likely take years to have significant impact, and they may have limited effect on the existing provider market power that underlies current high prices. As a result, we believe regulatory action is needed and that this action must be multifaceted. We propose a system of “Cadillac” price caps at the local market level to constrain the most highly priced instances of a service, coupled with price

growth regulation to ensure that no service’s price grows at runaway speed, all while maintaining reasonable access to services and preserving markets. Last, we propose that the regulatory statutes be enforced by authorities with the ability to compel providers and insurers to adhere to both the letter and the spirit of the law. Within this system, market forces can retain a meaningful role, both to inform relative prices and to reward efficient providers with greater volume and (depending on the market and provider) higher prices.

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Endnotes

1. While enforcers can challenge consummated mergers, such challenges are rare and become even more difficult as time passes and organizations integrate their operations. Even if enforcers are successful in defending against every appeal of an initial decision, by the time they attempt to enforce a divestiture order, the process can be so difficult that it is referred to as “unscrambling an egg.”
2. That is, for markets in which the 20th percentile is very high, we would instead use the 75th percentile of all 20th percentiles across the nation. Exceptions would be appropriate in very high input cost areas, such as Alaska.
3. Based on authors’ analysis of 2017 Health Care Cost Institute (HCCI) data. We estimate the impact of inpatient facility price caps on inpatient facility spending as an illustration only. Our proposal is meant to apply to provider (facility and professional) prices more generally.
4. Voluntary total spending growth targets have been piloted in Massachusetts (Cutler and Walsh 2016), Delaware (Newman 2018), and Rhode Island (Gregg 2019), demonstrating appetite among some states for such regulation. Oregon has enacted a total health-care spending growth target to be implemented in 2021 (Oregon Health Authority Office of Health Policy n.d.).
5. Another area for enforcers to explore is whether price caps that constrain prices in certain provider-service-insurer units results in gaming whereby the provider seeks to raise prices in other areas where the price cap exceeds pricing levels. While price growth caps are designed to minimize this potential effect, enforcers should be mindful of this risk and consider it in their review.
6. In addition, state authority over providers can potentially avoid ERISA barriers to enforcement.
7. In a national sample of three large health insurers covering roughly 43 million people in 2016 alone, about 8.8 percent of spending on health-care professionals was OON, and about 3.2 percent was for OON services within INN facilities. Of the latter, 58.2 percent of spending was attributable to prices above national service-specific median INN prices (i.e., 41.8 percent of surprise bill spending was no higher than it would have been for the same services at their national median INN prices; Chernew, Pany, and Frank 2019).
8. Medicare bundles payments for related outpatient facility services, but not for office-based physician services, into so-called Ambulatory Payment Classifications (APCs), which are aggregates of individual service codes (CPT/HCPCS codes). Many commercial insurers reimburse both outpatient facilities and office-based physicians using individual service codes.
9. We recommend that the formula adopted by regulators to implement the price growth cap incorporate a continuous rather than a discrete measure of distance between a provider’s price and the benchmark price (e.g., 20th percentile of market price).
10. These states are Colorado, Delaware, Massachusetts, Maine, and Virginia.
11. *Gobeille v. Liberty Mut. Ins. Co.*, No. 14–181, 577 US (2016).
12. *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

References

- All-Payer Claims Database (APCD) Council. n.d. "APCD Legislation by State." All-Payer Claims Database (APCD) Council, Durham, NH.
- Baum, Aaron, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu. 2019. "Health Care Spending Slowed after Rhode Island Applied Affordability Standards to Commercial Insurers." *Health Affairs* 38 (2): 237–45.
- Beaulieu, Nancy D., Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams. 2020. "Changes in Quality of Care after Hospital Mergers and Acquisitions." *New England Journal of Medicine* 382 (1): 51–59.
- Becerra, Xavier. 2019, December 20. "Attorney General Becerra: State, Unions, Employers, and Workers Reach Settlement to Address Alleged Anticompetitive Practices by Sutter Health That Increased Healthcare Costs for Californians." Press release, State of California Department of Justice Office of the Attorney General, Sacramento, CA.
- Berenson, Robert A., Jonathan H. Sunshine, David Helms, and Emily Lawton. 2015. "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." *Health Affairs* 34 (8): 1289–95.
- Bluth, Rachel. 2019, June 20. "1 in 6 Insured Hospital Patients Get a Surprise Bill for Out-of-Network Care." *Kaiser Health News*.
- Bodenheimer, Thomas, Robert A. Berenson, and Paul Rudolf. 2007. "The Primary Care–Specialty Income Gap: Why It Matters." *Annals of Internal Medicine* 146 (4): 301–6.
- Brot-Goldberg, Zarek C., Amitabh Chandra, Benjamin R. Handel, and Jonathan T. Kolstad. 2017. "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics." *Quarterly Journal of Economics* 132 (3): 1261–1318.
- Bureau of Labor Statistics. 2019. "Measuring Price Change in the CPI: Medical Care." Bureau of Labor Statistics, U.S. Department of Labor, Washington, DC.
- Capps, Cory. 2014. "From Rockford to Joplin and back again: The Impact of Economics on Hospital Merger Enforcement." *The Antitrust Bulletin* 59 (3): 443–78.
- Capps, Cory, David Dranove, and Christopher Ody. 2017. "Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene." *Health Affairs* 36 (9): 1556–63.
- Centers for Medicare & Medicaid Services. 2018. *Physician Fee Schedule CY 2019*. Baltimore, MD: Centers for Medicare & Medicaid Services.
- Chan, David C., Jr., and Michael J. Dickstein. 2018. "Industry Input in Policymaking: Evidence from Medicare." Working Paper 24354, National Bureau of Economic Research, Cambridge, MA.
- Chen, Julius L., Andrew L. Hicks, and Michael E. Chernew. 2018. "Prices for Physician Services in Medicare Advantage versus Traditional Medicare." *American Journal of Managed Care* 24 (7): 341–44.
- Chernew, Michael E., Maximilian J. Pany, and Richard G. Frank. 2019, September 3. "The Case for Market-Based Price Caps." *Health Affairs (blog)*.
- Clemens, Jeffrey, and Joshua D. Gottlieb. 2016. "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments." *Journal of Political Economy* 125 (1): 1–39.
- Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *Quarterly Journal of Economics* 134 (1): 51–107.
- Cooper, Zack, Stuart V. Craig, Charles Gray, Martin Gaynor, and John Van Reenen. 2019. "Variation In Health Spending Growth For The Privately Insured From 2007 To 2014." *Health Affairs* 38 (2): 230–236.
- Cutler, David, and Leemore Dafny. 2011. "Designing Transparency Systems for Medical Care Prices." *New England Journal of Medicine* 364 (10): 894–95.
- Cutler, David, and Steven M. Walsh. 2016, May 11. "The Massachusetts Target on Medical Spending Growth." *NEJM Catalyst*.
- Dafny, Leemore S. 2018. "Health Care Industry Consolidation: What Is Happening, Why It Matters, and What Public Agencies Might Want to Do about It." Testimony of Leemore S. Dafny, Ph.D., Bruce V. Rauner Professor of Business Administration, Harvard Business School, Harvard John F. Kennedy School of Government, Before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations, February 14, Washington, DC.
- Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan. 2012. "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry." *American Economic Review* 102 (2): 1161–85.
- Dafny, Leemore, Kate Ho, and Robin S. Lee. 2019. "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry." *RAND Journal of Economics* 50 (2): 286–325.

- Desai, Sunita, Laura A. Hatfield, Andrew L. Hicks, Anna D. Sinaiko, Michael E. Chernew, David Cowling, Santosh Gautam, Sze-jung Wu, and Ateev Mehrotra. 2017. "Offering a Price Transparency Tool Did Not Reduce Overall Spending among California Public Employees and Retirees." *Health Affairs* 36 (8): 1401–7.
- Frank, Matthew B., John Hsu, Mary Beth Landrum, and Michael E. Chernew. 2015. "The Impact of a Tiered Network on Hospital Choice." *Health Services Research* 50 (5): 1628–48.
- Fulton, Brent D. 2017. "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses." *Health Affairs* 36 (9): 1530–38.
- Fulton, Brent D., Daniel R. Arnold, and Richard M. Scheffler. 2018, July 30. "Market Concentration Variation of Health Care Providers and Health Insurers in the United States." *To the Point* (blog).
- Gaynor, Martin, Kate Ho, and Robert J. Town. 2015. "The Industrial Organization of Health-Care Markets." *Journal of Economic Literature* 53 (2): 235–84.
- Gregg, Katherine. 2019, February 6. "Raimondo Order Creates Target for Limiting Growth of Health-Care Costs." *Providence Journal*.
- Guardado, Jose R., David W. Emmons, and Carol K. Kane. 2013. "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra." *Health Management, Policy and Innovation* 1 (3): 16–35.
- Haber, Susan, Heather Beil, Peter Amico, Marisa Morrison, Valentina Akhmerova, Christopher Beadles, Olivia Berzin, Maggie Cole-Beebe, Alon Evron, Leslie Greenwald, Linda Jiang, Konny Kim, Marianne Kluckman, Sophia Kwon, Timothy O'Brien, Rebecca Perry, and Alton Wright. 2018, March. *Evaluation of the Maryland All-Payer Model: Third Annual Report*. RTI International, Waltham, MA. Prepared for Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, Baltimore, MD.
- Hargraves, John, and Aaron Blotchichak. 2019, December 17. "International Comparisons of Health Care Prices from the 2017 iFHP Survey." *Health Care Cost Institute* (blog).
- Health Care Cost Institute. 2019. *2017 Health Care Cost and Utilization Report*. Washington, DC: Health Care Cost Institute.
- . 2020. "HCCI Data." Database, Health Care Cost Institute, Washington, DC.
- IBM. 2020. "IBM MarketScan Research Databases." Database, IBM, Armonk, NY.
- Kaiser Family Foundation. 2019, September 25. "2019 Employer Health Benefits Survey: Section 14: Employer Practices and Health Plan Networks." Henry J. Kaiser Family Foundation, San Francisco, CA.
- Kennedy, Kevin, William Johnson, Sally Rodriguez, and Niall Brennan. 2019, April 30. "Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area." *Health Care Cost Institute* (blog).
- Laugesen, Miriam J., and Sherry A. Glied. 2011. "Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries." *Health Affairs* 30 (9): 1647–56.
- McWilliams, J. Michael, Laura A. Hatfield, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. 2016. "Early Performance of Accountable Care Organizations in Medicare." *New England Journal of Medicine* 374 (24): 2357–66.
- Mehrotra, Ateev, Tyler Brannen, and Anna D. Sinaiko. 2014. "Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?" *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 51: 1–3.
- Mehrotra, Ateev, Michael E. Chernew, and Anna D. Sinaiko. 2018. "Promise and Reality of Price Transparency." *New England Journal of Medicine* 378 (14): 1348–54.
- Neuman, Tricia, Karen Pollitz, Jennifer Tolbert, Robin Rudowitz, and Wyatt Koma. 2019, December 18. "10 Key Questions on Public Option Proposals." Issue Brief, Henry J. Kaiser Family Foundation, San Francisco, CA.
- Newman, Meredith. 2018, November 20. "State Plans to Keep the Growth of Health Care Costs under 4 Percent." *The News Journal*.
- Oregon Health Authority Office of Health Policy. n.d. "Sustainable Health Care Cost Growth Target." Office of Health Policy, Oregon Health Authority, Salem, OR.
- Prager, Elena. 2015. "Tiered Hospital Networks, Health Care Demand, and Prices." Working paper, University of Pennsylvania, Philadelphia, PA.
- Reger, Alex. 2016. "Rhode Island's Health Insurance 'Affordability Standards.'" OLR Research Report, Office of Legislative Research, Connecticut Assembly, Hartford, CT.
- Roberts, Eric T., Michael E. Chernew, and J. Michael McWilliams. 2017. "Market Share Matters: Evidence of Insurer and Provider Bargaining over Prices." *Health Affairs* 36 (1): 141–48.

- Robinson, James C., and Timothy T. Brown. 2013. "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery." *Health Affairs* 32 (8): 1392–97.
- Sinaiko, Anna D., Shehnaz Alidina, and Ateev Mehrotra. 2019. "Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?" *American Journal of Managed Care* 25 (2): 85–88.
- Sinaiko, Anna D., Mary Beth Landrum, and Michael E. Chernew. 2017. "Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent." *Health Affairs* 36 (5): 870–75.
- Sinsky, Christine A., and David C. Dugdale. 2013. "Medicare Payment for Cognitive vs Procedural Care: Minding the Gap." *JAMA Internal Medicine* 173 (18): 1733–37.
- Song, Zirui, Yunan Ji, Dana G. Safran, and Michael E. Chernew. 2019. "Health Care Spending, Utilization, and Quality 8 Years into Global Payment." *New England Journal of Medicine* 381 (3): 252–63.
- Trish, Erin, Paul Ginsburg, Laura Gascue, and Geoffrey Joyce. 2017. "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance." *JAMA Internal Medicine* 177 (9): 1287–95.
- United States District Court for the Western District of North Carolina Charlotte Division. 2018. "United States of America and State of North Carolina v. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System." United States District Court for the Western District of North Carolina Charlotte Division, Charlotte, NC.
- Waber, Rebecca L., Baba Shiv, Ziv Carmon, and Dan Ariely. 2008. "Commercial Features of Placebo and Therapeutic Efficacy." *JAMA* 299 (9): 1016–17.
- White, Chapin, and Vivian Yaling Wu. 2014. "How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices?" *Health Services Research* 49 (1): 11–31.



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Highlights

In this paper, Michael Chernew of Harvard Medical School, Leemore Dafny of Harvard Business School, and Maximilian Pany of Harvard University argue that high and rising commercial prices for health-care services constitute a core policy challenge. To an important extent, high and variable prices reflect market failures that can only be partially addressed through pro-competitive measures. Chernew, Dafny, and Pany propose a three-pronged approach for addressing the highest health-care prices: capping service prices, limiting annual price growth for these services, and implementing flexible regulatory oversight.

The Proposal

Set rate caps to limit prices for health-care services at the very top of the (in-network and out-of-network) commercial price distribution. “Cadillac” caps can address the most egregiously high prices immediately. Caps would vary across markets and would be set using data on prevailing commercial prices in each market. Caps would generally be equal to five times the 20th percentile of the commercial price distribution in a given market.

Place an annual cap on service-, insurer-, and provider-specific price growth that inversely varies with provider price. Limiting price growth achieves goals that level caps cannot accomplish, affecting a wider range of providers and encouraging high-price providers to become more efficient. Over time, a growth-rate cap that inversely varies with provider price will likely induce greater convergence of prices across providers but should be set to preserve enough price variation to reward higher performance.

Implement flexible oversight by federal and/or state agencies that would be triggered when expenditure or premium growth exceeds predetermined thresholds. Because of the potential for providers to circumvent price caps, some review at the aggregate spending or premium level will be needed to ensure the intent of the policy is not evaded through gaming, recoding, or payments outside of the fee-for-service system.

Benefits

High and rising commercial prices for health-care services present a core policy challenge. But price caps based on commercial rates can address this problem while maintaining market-based incentives. Lower prices in the commercial sector will pressure providers to deliver care more efficiently and generate savings for payers and patients. For example, the authors estimate that the proposed caps would directly affect 4.5 percent of inpatient admissions, 84.3 percent of providers, and 89.3 percent of markets, and would save 8.7 percent of inpatient spending.



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