

Cap Provider Payment Rates or Rate Increases

Cost Driver Targeted: Provider (primarily hospital) prices

OVERVIEW

Provider price growth is a leading driver of health care cost growth in the commercial market, and a number of states are implementing or considering strategies to directly address high provider prices or price growth. For example, Massachusetts' Health Policy Commission recommended a number of strategies, including capping provider prices and adopting a default out-of-network payment rate, in its [2021 Annual Health Care Cost Trends Report](#).

Oregon was one of the first states to cap hospital prices in its [public employee benefit program](#), limiting payments for in-network hospital services to 200 percent of the amount Medicare would pay for the services and limiting payments for out-of-network hospitals to 185 percent of the amount Medicare would pay. Building on these efforts, states have broadened their lens with a focus on addressing high prices across the commercial market.¹ Notably, Rhode Island has a cap on provider rate increases enforced through insurance rate review. Rhode Island's "[affordability standards](#)" for all commercial insurers in the state include annual price inflation caps equal to inflation plus 1 percent for both hospital inpatient and outpatient services. Delaware recently enacted a law that similarly caps price growth for nonprofessional services at hospitals for fully insured payers.



¹ Montana uses reference-based pricing in its public employee health plan, and North Carolina proposed to do the same. Although these reference-based pricing approaches are similar in that they limit reimbursement rates to providers, they are employed as purchasing strategies and are not geared toward influencing the commercial market as a whole.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine whether to cap prices or price increases.

Capping prices (at a certain percentile of median price or based on Medicare rates) directly addresses provider price variation by limiting the amount that can be charged by the highest-cost providers. This approach can be politically difficult, however, as often these higher-priced providers have strong market and political clout. There is also a risk that lower-priced providers would increase their rates up to the cap, thus reducing the potential for savings. Alternatively, addressing price increases perpetuates baseline discrepancies in payment rates but has the advantage of potentially being less disruptive to existing pricing structures. Capping prices and capping price increases are not mutually exclusive, however, and a state could potentially use both approaches.

Define which prices to include. Rhode Island's and Delaware's initiatives to limit hospital rate increases have encompassed both hospital inpatient and outpatient prices. However, states could consider starting with a more limited (or, for that a matter, a broader) set of prices. For example, Oregon's initiative began with joint replacements in 2015 before expanding to all hospital payments in 2017. States also could apply price caps and/or price growth caps to professional services. Some proposals on capping out-of-network payments have focused on particularly costly services for consumers, such as pathology, emergency, anesthesiology, and radiology services.

Establish oversight for the program. Rhode Island's and Delaware's programs use insurance oversight as the regulatory mechanism for caps on price increases. Rhode Island's cap on rate increases is built into its health insurance affordability standards, which are enforced by its Office of the Health Insurance Commissioner through the rate review process. Similarly, Delaware's law uses the rate review process to implement its cap on rate increases. Having statutory authority for oversight as well as adequate staff capacity will help states effectively implement this type of strategy.

EVIDENCE OF IMPACT

Controlling prices and price increases has a direct effect on health care spending. The size of the effect will depend on the number of prices and price increases being capped, and the aggressiveness of the cap.

Oregon's program to cap payments in its public employee benefit program had an estimated initial savings of \$81 million, representing roughly 5 percent of total costs. A study of **Rhode Island's affordability standards**, which apply to the fully insured market, found a 2.7 percent decrease in total spending growth from 2010 to 2016 compared with matched controls in other states, with the effect more pronounced after three years following policy adoption. Utilization did not change significantly, suggesting that the decrease in spending was driven primarily by lower prices.

Nationally, many different proposals to institute price caps across the commercial market have been modeled, with all suggesting the possibility of significant savings. **Limiting out-of-network payments** to 125 percent of Medicare payments is estimated to yield a \$108 billion to \$124 billion reduction in nationwide hospital spending, whereas capping payments at 200 percent of Medicare payments is estimated to reduce hospital spending by \$56 billion to \$94 billion. Setting prices for all commercial payers at 100 percent to 150 percent of Medicare rates could **reduce hospital spending** by \$61.9 billion to \$236.6 billion, equivalent to a 1.7 percent to 6.5 percent reduction in national health spending. Another proposal that would cap commercial hospital prices at five times the 20th percentile price is **estimated to save \$38 billion**, reducing commercial health care spending by about 3.2 percent and total health care spending by about 1.0 percent.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

This option is likely most attractive to states that:

- have a high degree of commercial price variability within their markets
- can obtain statutory authority to limit commercial insurer contractual rates and/or rate increases
- have adequate staff capacity to oversee and enforce caps
- are prepared and able to work through provider opposition.

States that have pursued caps on rate increases in the commercial market have tended to be more progressive states that feel comfortable taking a regulatory approach.

EQUITY CONSIDERATIONS

Strategies that cap price increases, rather than prices, inherently perpetuate underlying disparities in payment rates and could potentially harm provider organizations that care for underserved or low-income communities. Pursuing such a strategy will require carefully monitoring and mitigating the impact on rural, safety-net, and other providers that might have lower commercial payer reimbursements. Rhode Island incorporated a one-time adjustment for hospitals with the lowest prices to address this issue.

However, bringing up low rates without an offsetting decrease or slowed increase to high rates will reduce savings. Capping rates may cause lower-priced providers to raise their prices up to the cap; although this would lead to more equitable payment rates, it would negate the potential for cost savings.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

States that cap payment rates only in certain programs (e.g., state employee health benefit programs or public option plans) may inadvertently dissuade providers from participating. This has been a challenge for Washington's public option, which caps provider payment rates at 160 percent of Medicare rates.

If caps are applied more broadly across the market, downward pressure on hospitals' prices would ultimately reduce margins. Hospitals might try to increase volume to compensate, and states would need to monitor for this effect. Decreased margins also could put pressure on hospitals to close unprofitable service lines or to close entirely, which could affect access to care. Hospitals could hypothetically also reduce staffing or investments in quality, making it important for states to monitor for access and quality effects.

RESOURCE

Aaron Baum et al., "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers," *Health Affairs* 38, no. 2 (Feb. 2019): 237–45.