

# Limiting the Rate of Growth in Provider Prices

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Rapidly growing prices are the [major driver of health care cost growth](#) in the commercial market. From 2016 to 2020, the increase in health care spending was driven entirely by rising average prices, which grew by nearly 16 percent while utilization declined by 5.4 percent. Hospital inpatient prices had the greatest increase (24.6%). Hospital inpatient care, hospital outpatient care, and professional services accounted for over three-quarters (77%) of total spending. Thus, to successfully contain health care cost growth in the commercial sector, states will need to address the growth in provider prices.

To limit health care cost growth, two states — Rhode Island and Delaware — have established caps on how much provider prices can grow each year. By directly influencing a key driver of health care cost growth, provider price growth caps can be highly effective in constraining costs. According to an independent study, following Rhode Island's implementation of its affordability standards, there was a \$55, or 5.8 percent, net [decrease in quarterly total health care spending](#) per commercially insured enrollee, relative to a control population.

The following steps present a sequence of important decisions for states to work through. States should be prepared for a process that is both *iterative*, where questions may need to be revisited over time, and *dynamic*, to account for new questions and new answers that may emerge.

**Step 1.** Establish goals for adopting price growth caps and confirm readiness to proceed.

**Step 2.** Identify and secure the authority that will be needed to cap the growth of provider rates.

**Step 3.** Determine which prices will be subject to the growth cap.

**Step 4.** Set the level of the cap.

**Step 5.** Determine whether to apply the cap to individual service prices, individual provider entities, or to an aggregation of services and provider entities.

**Step 6.** Consider incorporating quality measurement and incentives.

**Step 7.** Consider adjustments or other mechanisms to address underlying payment disparities.

**Step 8.** Design, implement, monitor, and evaluate the program with equity at the center.

**Step 9.** Plan for effective oversight.

**Step 10.** Take steps to mitigate gaming the system.

**Step 11.** Identify and secure the analytic resources needed.

**Step 12.** Engage stakeholders throughout design, implementation, and evaluation.

## **Step 1. Establish goals for adopting price growth caps and confirm readiness to proceed.**

*Goal development.* A clearly articulated and widely supported set of goals will provide stakeholders with clarity on what the state aims to achieve. The goal-definition process needs to involve key state agency actors, such as the health insurance regulatory agency, the agency regulating hospitals, the Medicaid agency, and the state employee benefits program. This can be performed with all actors assembled or through a series of individual conversations. Collaboration across state agencies and with the legislature is important for success.

## State Approaches to Capping Growth in Provider Prices

In 2010, **Rhode Island**'s Office of the Health Insurance Commissioner implemented a set of [affordability standards](#) for all commercial insurers in the state. Among other requirements, the standards limited the average annual rates of price increase for both inpatient and outpatient services within each provider contract. These standards have been updated over time but continue to constrain price growth for inpatient and outpatient services.

In 2020, **Delaware**'s Office of Value-based Health Care Delivery developed provisional [affordability standards](#) that included caps designed to decrease price growth. Delaware's caps apply to commercial health insurance carrier contracts with health care providers. They limit aggregate unit price growth for nonprofessional services, which include inpatient hospital, outpatient hospital, and "other" nonprofessional medical services.<sup>1</sup> In 2021, the Delaware General Assembly enacted legislation establishing these affordability standards in statute, and [regulations for their enforcement](#) were issued in 2022.

<sup>1</sup> Carriers are instructed to use the definitions for these categories that they use when completing the Unified Rate Review Template.

Improving the affordability of health care is the most obvious goal. A price growth cap can:

- help improve affordability for consumers, employers, and other payers
- provide more predictability in year-over-year cost growth
- help constrain the market power of providers, particularly providers with significant market clout, in demanding price increases.

Price growth caps can also support additional secondary goals, and the relative importance of some of these goals will help inform the state's design decisions. One important secondary goal is transparency: Establishing a growth rate cap lets consumers and purchasers know how much provider prices are allowed to increase from year to year and signals that the state is taking concrete action to address an issue of great public concern.

Implementing price growth caps can also be used to redirect health care dollars from more generously resourced health care sectors to under-resourced sectors. For example, **Delaware** implemented its price growth caps to support increased investments in primary care. This need was identified through an extensive stakeholder engagement process along with data-driven analysis. Engaging stakeholders in defining the goals and being clear about those goals is essential when designing the program and communicating its importance.

*Environmental assessment.* Each state's environment is unique and will change over time. Before committing to a large-scale initiative to establish price growth caps, the following questions should be addressed.

- Is there sufficient state government leadership support, including in the governor's office and among state agency leadership and legislative leadership?
- Are key external stakeholders willing and able to collaborate?
- Are there sufficient resources inside and outside the state to provide the necessary staff and financial support?

An environmental assessment will be necessary at the outset to determine the perspectives of key stakeholders and where there may be opportunities and barriers. First, state leaders who can champion provider growth caps should be identified. Conversations with a range of stakeholders and other knowledgeable parties will be valuable in determining external support and readiness (with the recognition that some stakeholders will likely oppose the policy). These could include:

- consumer advocates and community organizations
- labor
- employer purchasers, including public employee benefit programs
- insurers
- hospitals, health systems, and other provider organizations
- legislators
- state agencies.

Finally, the state should evaluate the availability of financial and personnel resources (including contracted personnel) that will be needed to support this work — or the likelihood of obtaining these resources.

*Deciding whether to proceed.* Results from the preceding activities will inform the state's decision on whether circumstances are ripe for proceeding with provider price growth caps. Because of the considerable effort required to succeed, the effort should move forward only if state leaders are confident there is a sufficient window of opportunity.

## **Step 2. Identify and secure the authority that will be needed to cap growth of provider rates.**

States will most likely need to pass legislation to secure the needed authority. The two states that have implemented provider price growth caps, Delaware and Rhode Island, both built their caps into their authority to regulate health insurers. Delaware's caps are written into statute, whereas Rhode Island established its caps through the state's regulatory affordability standards.

In both instances, the states require insurers to limit the growth of prices through their contracts with providers. This approach has the benefit of building on states' existing regulatory structure for overseeing health insurance carriers. The main drawback is that states' oversight authority for health insurance carriers applies only to carriers' fully insured business. That authority does not extend to self-insured plans, which make up a sizeable and growing percentage of the commercial market. That said, given purchasers' shared interest in containing health care costs, states can reach out to employer purchasers and administrators of self-insured plans to build support and encourage voluntary participation. There will also likely be spillover effects into the self-insured market, because plans may negotiate a single set of provider rates that apply to both their insured and self-insured plans.

Some states have or could acquire the authority to regulate provider prices directly. While the majority of states had the ability to set hospital rates in the past, Maryland is the only state that continues to set rates for hospitals. In addition, Vermont has the authority to review hospital budgets and to set provider rates.

States seeking new authority will need to ensure that it extends beyond "chargemaster" prices to regulate payer-

specific contract rates. Regulating provider reimbursement rates directly will require creating and implementing an oversight mechanism. This might be more feasible if the state anticipates regulating rates for a smaller number of larger provider organizations, such as hospitals, rather than smaller provider entities, such as individual physicians or physician practices.

## **Step 3. Determine which prices will be subject to the growth cap.**

This critical design decision should be informed by data and careful analysis, so that states can clearly articulate the need for the growth cap and its likely impact on health care cost growth. Sectors that are large contributors to health care spending growth over time should be identified.

## **Step 4. Set the level of the cap.**

The level at which states set their cap is important: If it is too high, there will not be sufficient cost containment. If it is set too low, there could be deleterious consequences for the system's financial stability and ability to provide high-quality care.

States may wish to tie their price growth cap to an economic indicator so that health care prices do not grow faster than other parts of the economy. Both Rhode Island and Delaware use measures of inflation, specifically the consumer price index (CPI) minus food and energy (referred to as "Core" CPI). Using a measure like CPI or Core CPI has the benefit of relying on a broadly reported and commonly understood measure that is salient to consumers and employers. CPI is not specific to the prices generated by the health care sector, which some states perceive as an advantage because it brings health care price growth more in line with overall (and generally lower) price growth in the broader economy. States may want to smooth out fluctuations in indicators like CPI, such as by averaging values over a two- or three-year period.

States that prefer to use more health care-specific indicators could consider using the [Medicare market baskets](#), which are calculated for many of the Medicare payment systems, including for inpatient hospitals, physician fees (the Medicare Economic Index), skilled nursing facilities, and home health agencies. States could also use other economic indicators, such as the [Personal Consumption Expenditures Price Index](#), which the Federal Reserve uses; measures of a state's economic productivity

(potential gross state product); or household wages or income. When selecting an indicator, states can consider criteria such as selecting a publicly available indicator, an indicator that is relatively stable over time, or an indicator that reflects the economic earnings or purchasing power of consumers or businesses.

States can also use a fixed number and adjust the cap over time. For example, Delaware established its cap for 2022

at the greater of 3 percent or Core CPI plus 1 percentage point. This then decreases in 2023 to the greater of 2.5 percent or Core CPI plus 1 percentage point. In 2024, 2025, and 2026, it decreases to the greater of 2 percent or Core CPI plus 1 percentage point.

States will likely need to consider if there are extenuating circumstances requiring flexibility in the level of the cap or in its enforcement.

### Categories of Prices for States to Examine

Category of prices	Notes
Hospital inpatient and outpatient services	Delaware and Rhode Island have focused on hospital price growth caps.
Professional services	Rhode Island is exploring capping the <a href="#">growth rate of professional services</a> . Professional services make up a large segment of health care spending in the commercial market ( <a href="#">almost one-third</a> in one recent analysis). Capping their price growth will likely have a sizeable impact on prices.
Postacute care and home health services, particularly those provided by hospital-owned entities	Acute care hospitals increasingly own or have common <a href="#">investor ties to the postacute sector</a> . Including these services within a growth cap might decrease incentives to increase prices elsewhere in the continuum of care. However, for the commercial market, they are unlikely to make up a large percentage of total health care spending. Delaware’s cap applies to all non-professional services, which include inpatient hospital, outpatient hospital, and “other” nonprofessional medical services such as ambulance, home health care, durable medical equipment, prosthetics, and supplies.
Freestanding health care facilities, specifically ambulatory surgery centers, freestanding imaging centers, urgent care clinics, and emergency rooms	Including these provider types within a cap could help prevent differential pricing effects on similar services provided at different sites. It could also prevent hospitals from affiliating with these facilities as a strategy for circumventing price caps.
Accountable care organizations (ACOs) (caps would apply to overall budgets rather than prices)	A state could consider capping total-cost-of-care budget increases for ACOs. For example, Rhode Island has capped insurer budget increases for population-based contracts at the Consumer Price Index (CPI) plus 1.5 percent.
Pharmacy spending	While not a focus of this series, it is worth noting that pharmacy prices are a major driver of health care costs and cost growth across the country. Some states have proposed legislation that would <a href="#">cap the growth in pharmacy prices</a> . Connecticut Governor Lamont, for example, refiled legislation in 2022 that would penalize manufacturers of products whose prices <a href="#">grow more than CPI plus 2 percent</a> . Massachusetts Governor Baker refiled similar legislation that penalized manufacturers of products whose prices <a href="#">rose more than the three-year average of core CPI</a> (CPI minus food and energy). Federal proposals to constrain pharmacy price growth are also pending.

### Step 5. Determine whether to apply the cap individually or in aggregate.

States could theoretically apply their growth cap to each price individually (meaning that no individual price could increase more than the cap), or in the aggregate (for example, a weighted average of all inpatient prices). An aggregate approach may be more adaptable across different types of payment methods (such as bundled payments) and easier to implement.

States could also differ in whether they apply their cap to each provider contract or across multiple provider contracts. **Delaware's** cap is applied on an aggregate basis across all contracted hospital providers within a carrier's network, which means that price increases can differ for different institutions. **Rhode Island's** affordability standards cap the weighted average rate increases in each hospital contract. One consideration in determining whether the cap should be applied on a contract-by-contract or an aggregate basis is how states plan to audit and ensure compliance with the requirement, such as through reviewing payer contracts with providers or comparing trend information provided within rate filing data.

### Step 6. Consider incorporating quality measurement and incentives.

Both **Rhode Island** and **Delaware** include price growth caps as part of a comprehensive set of standards that address other aspects of health system reform, including primary care investment, value-based payment, and quality initiatives. Even when implementing price caps as a stand-alone strategy, a quality incentive component might be desirable. For example, Rhode Island's affordability standards require all commercial insurer hospital contracts to include a quality incentive program. And they stipulate that a percentage of an annual rate increase must be predicated on achieving specified quality performance targets. Like Rhode Island, states could specify the percentage of the allowed increase each year that will be contingent on quality or equity improvements. Quality incentive payments should be included in the growth cap, lest they become a loophole for raising provider payment rates.

### Step 7. Consider adjustments or other mechanisms to address underlying payment disparities.

A growth rate cap inherently perpetuates underlying disparities in payment because, in absolute terms, higher-priced providers can continue to increase their rates

more (in absolute dollars) than lower-priced providers. Adjustments may be called for to remedy these payment disparities. For example:

- Rhode Island allowed for a [one-time adjustment](#) for hospitals that were reimbursed at less than the median rate for inpatient services only.
- Entity-specific price growth caps could be established, with some providers allowed to grow at faster rates than others. This approach, however, would increase the complexity of administration and might be subject to stakeholder litigation.
- Specific entities could be exempted from the cap, though at the risk of dampening the cost-containment effect.
- Price growth rate caps could be combined with [caps on prices](#) to rein in high-cost outliers.

### Step 8. Design, implement, monitor, and evaluate the program with equity at the center.

As noted above, one major risk of price growth caps is perpetuating and exacerbating existing disparities in payment. It's important for policymakers to closely monitor the financial health of facilities serving communities that have historically been marginalized and consider differential caps or adjustments as needed to ensure that these facilities are well-resourced and can provide high-quality care.

Also important is careful monitoring of access to care and patient experience of care across the population, with a focus on marginalized communities. Access to providers and quality of care require monitoring as well, and states might consider developing equity-focused quality benchmarks.

States can engage communities that are most affected by health inequities throughout the design and implementation of the program, as well as during program oversight. This can be done through direct community outreach and communication, establishment of advisory bodies, and partnering with community-based organizations.

### Step 9. Plan for effective oversight.

If a state is implementing this policy through regulations of health insurers, oversight will rest with the state's insurance department. There are many layers of oversight to consider, ranging from everyday communication to periodic examinations to enforcement actions.

## Layers of Oversight

Strategy	Description
Communication	<ul style="list-style-type: none"> <li>States will need to communicate with regulated carriers about the policy and provide explanatory materials and responses to carrier questions.</li> <li>Communication may take place directly and through bulletins, letters, meetings, and webinars.</li> </ul>
Reporting	<ul style="list-style-type: none"> <li>Forms and templates will be needed to facilitate carrier reporting.</li> <li>In Rhode Island, when carriers submit rates for review, they include an attestation with their filing that indicates that they are in compliance with the affordability standards.</li> <li>Delaware developed a <a href="#">data submission manual</a> for carriers to follow in their rate filings; it requests information about primary care spending, adoption of alternative payment models, and projected price and utilization by service category.</li> </ul>
Review	<ul style="list-style-type: none"> <li>Data collected in the rate review process (for example, price trend information) can be examined to understand at a high level whether the caps are being effectively implemented.</li> <li>States may modify their rate review templates to collect information on price trends by service category to help facilitate these comparisons.</li> <li>Price trend information that is grossly incongruous with the rate cap may suggest the need for a market examination or other mechanism for investigating the disparity.</li> </ul>
Examination	<ul style="list-style-type: none"> <li>In addition to information routinely collected through the rate review process, there should be a plan to periodically examine carrier contracts to ensure compliance.</li> <li>Findings can be made public to promote transparency.</li> <li>States should consider building in both the authority and funding for these activities, such as by being able to charge carriers for the cost of examinations.</li> </ul>
Enforcement action	<ul style="list-style-type: none"> <li>Options for enforcement include the ability to disapprove rates, impose fines, or require a corrective action plan.</li> <li>Criteria that would trigger these actions should be included.</li> </ul>

### Step 10. Take steps to mitigate gaming the system.

Price controls are vulnerable to manipulation. Three obvious ways providers could respond to price growth caps are to increase utilization to compensate for lower price growth, increase prices that are outside the growth cap, and focus on coding practices to increase the measured case mix or clinical risk scores. States should monitor for these practices and build in strategies to mitigate them.

*Increased utilization.* Providers could respond to caps on price growth by trying to increase utilization. States should be able to detect these changes by monitoring total patient revenue, as well as the trends reported as part of rate review filings and through analysis of data in their all-payer claims database (APCD) (for states that have one). Concurrent use of total-cost-of-care contract

arrangements, where providers face financial penalties for exceeding a target budget, would decrease their incentive to try to drive up revenue by increasing volume. However, these arrangements may not put substantial amounts of providers' revenue at risk. **Rhode Island** has a concurrent growth cap on their ACO budgets and on inpatient and outpatient hospital prices.

*Increased spending on services not covered by the growth cap.* Providers could similarly respond to caps on price growth by increasing prices for services that are not included in the cap. For example, if professional services are not included, hospital systems that employ health care professionals may try to seek higher, offsetting increases in rates for professional services. States could detect this by monitoring total patient revenue and trend information reported as part of rate review and through analysis of APCD data.

(Requesting price and utilization trend data separately by category of service would facilitate this monitoring.)

Making price growth caps as comprehensive as possible (for example, by including professional services in the cap along with inpatient and outpatient services) can also help prevent this form of gaming, as could total-cost-of-care arrangements as noted above. And as noted in Step 6, quality incentives and other non-claims-based payments could be used to “escape” the price growth cap. Caps on total-cost-of-care arrangements and requirements that quality incentives be included within the price growth cap can help limit this channel for price increases.

*Coding practices.* Provider coding practices that change the measured case mix or clinical risk scores could increase the effective price per unit of service. States will therefore need to monitor for changes in calculated clinical risk that are discordant from expected population-level changes. States may need to address changes in coding by pursuing strategies such as limiting the annual growth in risk scores or normalizing risk scores. Because changes in coding practices could hamper states’ ability to assess compliance indirectly through monitoring of provider revenue and unit cost, states should also prepare to directly review fee schedule information.

### **Step 11. Identify and secure the analytic resources needed.**

Analytic resources are important in the design and monitoring of these programs. On the front end, being able to identify key drivers of health care cost growth is essential for helping to build the case for the state’s specific policy actions and aligning price growth caps with the sectors that contribute most to cost growth. It is also important to be able to model the impact of different growth caps and understand how those caps could affect affordability for consumers and the other policy goals of the state.

Once a program is implemented, states can identify the agency or agencies that would be able to provide data and analysis to support the following activities:

- Monitoring the financial health of hospitals, including reviewing hospital financial reports to examine changes in patient revenue and margins
- Measuring total health care spending and spending growth, ideally by sector and by provider organization, to monitor for shifting of costs between sectors and to ascertain the effect on overall spending growth

- Monitoring quality of care, access to care, and patient experience, stratified by key variables including race, ethnicity, age, income, disability status, sexual orientation, gender identity, and language
- Possibly commissioning independent evaluations to document the effectiveness of the approach and opportunities to improve programs over time.

### **Step 12. Engage stakeholders throughout design, implementation, and evaluation.**

Effective communications with the public about the need for the program and its goals throughout the development and implementation phases will be essential for success, as well as for overcoming almost certain provider opposition. The state will need to create a compelling business case for action while engaging providers as best they can.

The first step is to clearly define and illustrate the problem of high health care costs, and specifically, high provider prices. Helping consumers and employers understand the goals of the program is just as essential to building support. Public communication should use multiple channels in this phase and throughout the design and implementation phases, including community and town hall meetings, earned media, website postings, and social media.

Cultivating champions for the program is also important. These champions should include external partners, such as business leaders or consumers affected by high prices, as well as leaders within the administration and legislature.

In standing up the program, states will need to engage stakeholders and obtain their input. A state could use an existing stakeholder body or forum for this purpose, or it could create an advisory body specifically for this program.

### **Conclusion**

Capping price growth is a straightforward and effective strategy for controlling commercial health care cost growth. However, states will need to prepare for provider opposition to these caps and determine how to overcome it. State officials will also likely need to seek legislative authority to establish a program and, as they build their proposal, engage stakeholders and lay the necessary analytic groundwork. Oversight and monitoring activities, likely through insurance departments, will also require preparation. If they are successful, however, states should be rewarded with improved affordability for residents and businesses.

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## ACKNOWLEDGMENTS

The authors thank Mary Jo Condon, Lovisa Gustafsson, Cory King, and Robert Murray for their helpful comments on earlier drafts of this guide. Views expressed in this guide are solely those of the authors.

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*Editorial support was provided by Ingrid VanTuinen.*

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This guide is part of a series, *State Strategies for Controlling Health Care Costs: Implementation Guides*, available from the Commonwealth Fund at <https://www.commonwealthfund.org/publications/2023/jan/state-strategies-controlling-health-care-costs-implementation-guides>.





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