

Capping High Provider Prices

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Provider price increases are a leading driver of health care cost growth in the commercial market. Prices are negotiated between each insurer and provider organization, and commercial insurer payments to hospitals have been shown to **vary tremendously** — in some cases, running many times higher than Medicare payments. Moreover, different hospitals can charge **dramatically different prices** for the same service. Even within the same hospital, a service can have a **range of prices**, depending on who is paying.

Provider price caps seek to establish some modicum of pricing discipline, especially for hospitals or other providers that charge the most. Price caps can be applied to a narrow set of services or to a more comprehensive set of services. They can be applied to only specific types of insurance or applied more broadly across the insurance market. While taking differing approaches, Montana and Oregon have both achieved limits on hospital prices in their public employee health benefit programs:

- Starting in 2016, **Montana's** state employee health plan implemented Medicare reference-based pricing. Montana used its negotiating leverage to **limit hospital payments** in its state employee benefit plan to between 220 and 225 percent of Medicare fees for inpatient services and 230 to 250 percent of Medicare for outpatient services. This was estimated to save the state **\$47.8 million over three years**.
- In 2017, **Oregon** passed legislation that **caps hospital prices** in its public employee benefit program. Services and supplies provided by in-network providers are paid at up to 200 percent of the Medicare rate, and those provided by out-of-network providers are paid at up to 185 percent of the Medicare rate. A preliminary analysis estimates **\$81 million in annual savings**.

Looking beyond public employee benefit programs, in **Massachusetts** in 2022 then-Governor Charlie Baker proposed legislation to cap payments for “**unforeseen out-of-network services**” at the carrier’s median in-network rate. The state’s Health Policy Commission has also **proposed capping provider prices** and price growth and adopting a default out-of-network payment rate.

Because price caps directly affect a key driver of health care spending and spending growth, they are likely highly effective in constraining spending, though the magnitude of their impact will vary depending on how broadly and how aggressively they are applied. Both Montana and Oregon saw significant savings in their public employee benefit program related to their pricing strategies.

While other states have not yet implemented broader price caps, several national proposals to institute price caps across the commercial market have been modeled, and all suggest that significant savings are possible. For example:

- Limiting out-of-network payments to 125 percent of Medicare payments is estimated to yield an annual **reduction of \$108 billion to \$124 billion** in nationwide hospital spending.
- Capping these out-of-network payments at 200 percent of Medicare payments is estimated to reduce annual hospital spending by \$56 billion to \$94 billion.
- Capping commercial hospital prices at five times the 20th percentile price is **estimated to save \$38 billion** annually, reducing commercial health care spending by about 3.2 percent and total health care spending by about 1.0 percent.

The following steps present a sequence of important decisions states must 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 caps and confirm readiness to proceed.

Step 2. Determine what authority the state will need for capping provider prices.

Step 3. Determine which prices will be capped.

Step 4. Define the level of the cap.

Step 5. Take steps to mitigate gaming the system.

Step 6. Establish strategies for monitoring and overseeing programs.

Step 7. Identify and secure the analytic resources needed.

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

Step 9. Engage stakeholders throughout design, implementation, and evaluation.

Step 1. Establish goals for adopting price 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 should involve key state actors: representatives from health, human services, insurance, and state employee benefit programs; data and analytics agencies; and legislative leadership. This process can be performed with all actors assembled or through a series of individual conversations.

In addition to lowering overall health care costs for consumers and employers, policies to implement price caps can support a number of other goals. One important effect is to level the playing field as much as possible among providers, thus potentially cultivating a more competitive market. Price caps can do this by dampening or restraining the market power of the highest-price providers. Price caps can also conceivably be designed with “floors” that support underfunded providers. By putting an

upper limit on what providers can charge, price caps can change the negotiating dynamics between providers and payers, strengthening the position of payers. In addition, price caps can help increase transparency by establishing clear expectations for the upper limit of prices, giving consumers and purchasers more insight into the cost of what is being purchased.

Environmental assessment. Each state’s environment is unique and will change over time. Before committing to price caps, the state should consider these questions:

1. Is there sufficient leadership support in the governor’s office, in state agencies, and in the legislature?
2. Are key external stakeholders willing and able to collaborate?
3. Are there sufficient resources within and outside the state to provide necessary staff and financial support?

Each state should perform an environmental assessment at the outset to determine the perspectives of key stakeholders and where opportunities and barriers exist. First, the state should identify whether there is requisite state leadership to champion provider price caps. Next, conversations with key stakeholders and other knowledgeable parties can help ascertain external stakeholder support and readiness. State staff should consider the perspectives of a variety of stakeholders, including:

- 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. If resources are not already in place, the state should assess the likelihood that it can obtain those resources.

Deciding whether to proceed. States should undertake the preceding steps and use the results to inform their decision on whether the circumstances are ripe for proceeding with provider price caps. Because of the considerable effort required to succeed with such an endeavor, the state should move forward only if it is confident there is a sufficient window of opportunity for success.

Step 2. Determine what authority the state will need for capping provider prices.

States that are seeking to bring down costs in their public employee benefit programs may be able to achieve some provider rate reductions through negotiations alone. But states planning to go beyond this narrow application will need legislative authority to implement caps. This authority could be structured in different ways. States have implemented or considered instituting caps through a range of mechanisms.

Provider rate-setting authority. **Maryland** is unique in its current use of all-payer rate setting. In the late 1970s, more than [30 states had some form of hospital rate-setting](#). Some states could potentially require state-licensed providers to accept certain rates. For example, **Vermont's** Green Mountain Care Board has [rate-setting authority](#) and [oversight of hospital budgets](#).

Insurer regulation. So far, insurer regulation has been used to impose price *growth* caps in two states: **Rhode Island** and **Delaware**. But such authority could also be used to cap rates themselves, by imposing requirements on insurer contracts with providers. Using this approach would constrain prices negotiated for state-regulated insurance products, namely, those in fully insured markets. And it would likely have spillover effects, as insurers may be able to use their increased leverage in the fully insured market to apply downward pressure to prices in the self-insured market as well.

Insurer regulation for out-of-network rates: The **Massachusetts** Executive Office of Health and Human Services has recommended [adopting an out-of-network rate cap](#). In March 2022, then-Governor Baker filed legislation that included a [cap on rates for “unforeseen” out-of-network care](#) at the median in-network rate. The governor’s proposal situates oversight authority for these caps with the insurance commissioner.

Purchasing authority. States have constrained reimbursement rates within their public employee programs, either through negotiation or legislation. More recently, states that are implementing public option programs have considered rate caps specifically for such plans.

Examples of Provider Price Caps in Public Programs

Program	State examples
Public employee programs	<ul style="list-style-type: none"> Montana’s public employee plan successfully negotiated with providers to accept rates that were 220 to 225 percent of Medicare rates for inpatient services and 230 to 250 percent for outpatient services. Oregon passed legislation limiting hospital payments in its public employee benefit program to 200 percent of Medicare rates for in-network hospital services and 185 percent for out-of-network hospitals.
Public option	<ul style="list-style-type: none"> Washington’s public option caps aggregate provider reimbursement at 160 percent of Medicare rates, with floors set for Critical Access Hospitals and primary care services. Colorado gives the insurance commissioner the ability to set rates should public-option plans fail to meet defined premium-reduction targets.

These approaches may significantly improve affordability within their specific programs, and they can directly affect state budgets. But their effects on the health care market as a whole are less certain, as they could have positive or

negative spillover effects in other market segments. They also run the risk that providers will simply choose not to participate in these plans.

Step 3. Determine which prices will be capped.

Before designing their programs, states should analyze

spending data to identify sectors that are substantial contributors to spending and find where there is significant provider price variation.

Categories of Prices That States Should Examine

Category of prices	Description
Hospital inpatient and outpatient	A focus of price growth caps as well as several national policy proposals. Increases in hospital prices are major driver of cost growth; hospital services are largest category of health care spending; and there is substantial price variation across hospitals.
Professional services (payments to physicians and other clinicians)	Professional services make up large segment of health care spending and are most common health service used by people with employer-based insurance.
Freestanding health care facilities: ambulatory surgery centers, freestanding imaging centers, urgent care clinics, emergency rooms	Including these facility 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 types of facilities to circumvent price caps.
Out-of-network rates	Some argue that imposing caps on out-of-network rates would give insurers more leverage in negotiating with hospitals and keeping them in network. Specifically, if out-of-network rates are capped at lower-than-typical in-network rates, providers have stronger incentive to reach agreement with insurer for acceptable in-network rate.
Pharmacy spending	Pharmacy spending is important contributor to health care cost growth, and many strategies have been proposed to address this sector.

Step 4. Define the level of the cap.

Once a state has decided to cap rates, it will need to take steps to define what the cap will be.

Select the rate structure to which the cap will be pegged. States that have pursued price caps have focused on hospital prices and have thus far tended to peg their rates to a percentage of Medicare rates. This approach is relatively straightforward for states from an administrative perspective, as Medicare rates are established federally and readily available. But while in many cases Medicare rates are lower than commercial market prices, the relative prices of services are not always consistent. And in some circumstances, Medicare rates can be higher than commercial rates, such as with certain maternity and pediatric services.

Another consideration is that Medicare payment methods, such as payment for hospital admissions on the basis of diagnosis-related groups (DRGs), are not uniformly used

across the market. If states rely on Medicare rates, they should be mindful that the effects of any future policy actions related to Medicare will be transmitted through the rate cap to the state’s commercial market.

Some researchers have proposed an alternative: set rates based on existing commercial prices, such as five times the 20th percentile price. The obvious advantage to this approach is that the rates by definition reflect what is being paid in the commercial market. However, states would need to establish a data source for these prices and make this information available in a timely manner.

Whichever mechanism states choose, they should include a “lesser of” provision so that the paid amount cannot be more than the previous year’s rate plus an inflation adjustment, or the chargemaster amount. Including such a provision is particularly important if the state adopts a rate schedule based on Medicare rates, because Medicare payments for some services can be far higher than current commercial rates.

Determine the level at which the cap should be set. To determine the cap, the state should conduct baseline analyses to understand current prices and hospital financials. Resources such as the National Academy for State Health Policy's (NASHP) [Hospital Cost Tool](#) can help states better understand hospital profitability and the reimbursement level at which hospitals broke even in the past. The state should be prepared to model the potential impact of the proposed cap on hospitals and other providers. This type of analysis was instrumental to the success of **Montana's** work to negotiate price caps in their state employee benefits program.

Consider whether the cap should be adjusted over time. States could adjust the percentile at which prices are capped to counteract price growth over time. For example, if Medicare rates rise and states wanted to avoid passing on those increases, states could consider decreasing the maximum allowed percentile for rates. Conversely, states could relax the price cap if circumstances warrant. States should develop criteria and a process for evaluating when modifications might be necessary.

Consider whether the state should include a price floor. Instituting a floor would support lower-priced providers and help narrow price variation, though it would decrease the savings obtained from capping rates. In negotiating rates with hospitals, **Montana's** state employee program set a target reimbursement rate that significantly narrowed variation. Before the reference-based pricing agreements, Montana paid a range of 191 to 322 percent of Medicare rates for inpatient services and 239 to 611 percent of Medicare rates for hospital outpatient services. The reference-based pricing agreements narrowed the range in prices paid by the health plan to 220 to 225 percent for inpatient services and 230 to 250 percent for outpatient services. **Washington State's** public-option caps set a floor of 101 percent of Medicare for Critical Access Hospitals and 135 percent of Medicare for primary care services.

Determine whether there should be a transition period. A transition period could help providers adjust to the new rates. For example, **Montana** included a three-year glide path for certain high-cost hospitals. However, a transition period might cut into savings in that initial period, and states would also need to monitor for price gaming in the time prior to when caps take effect (for example, sharp price increases). A transition also leaves a window of

time during which opponents of the policy could seek legislative changes to weaken or reverse it.

Establish whether caps are applied granularly or in aggregate. States could [apply a price cap broadly](#) across services instead of on a service-by-service. For example, the price caps in **Washington's** public option are set on an aggregate basis. A price cap could be applied to the average price per relative value unit or per DRG weight within each insurer-provider contract. For states that peg their caps to a percentile of existing commercial rates, this approach could avoid problems associated with small sample sizes for rare services. This aggregate approach could also make it easier to incorporate non-claims-based payments in the overall cap. States could also combine an aggregate cap with [caps on specific services](#).

Whether applying the cap in aggregate or granularly, states will need to develop a plan to monitor compliance. This could include payer attestations of compliance, as well as examinations of insurer-provider contracts.

Step 5. Take steps to mitigate gaming the system.

With any cap strategy, there is a risk that providers will find ways to game the system. For example, caps could become “floors” where all providers move their prices up to the cap. Also, caps could incentivize providers to shift price increases onto services that are not subject to the cap. Providers may also increase utilization of services or find other strategies to increase revenue.

Thus, as states design their price caps, they should consider how providers might try to game the system and implement approaches to mitigate it. States will need strong monitoring to detect changes in the market that could hamper the state's ability to achieve its policy goals, or that negatively impact access to or quality of care (described further below).

States could consider some of the following strategies to mitigate gaming.

Prevent providers from moving prices up to the cap. States could prevent this by [combining a price cap with a price growth cap](#), thereby limiting how much providers can increase prices in a particular year. Similar results could be achieved through a “lesser of” provision that does not allow the paid amount to exceed the previous year's

amount plus a certain percentage. This issue will be less of a concern if the price cap is set at a lower level.

Prevent providers from increasing revenue by moving price increases to other parts of the system or by increasing utilization. If prices are capped in one part of the system, providers, especially those with market power, might respond by pushing price increases or increasing utilization in other parts of the system. (This is less of an issue for caps that are more comprehensive.) Providers may also try to raise utilization to make up for lost revenue. One strategy for addressing these challenges is to incorporate alternative payment models that have incentives for meeting total-cost-of-care goals. Similarly, states could establish complementary caps on total medical expenditures or total medical expenditure growth.

Step 6. Establish strategies for monitoring and overseeing programs.

States should be prepared to monitor the following:

- *Hospital financials*, to ensure that hospitals are financially healthy and to see if there is evidence of gaming.
- *Spending and spending growth*, to check for shifting of costs between sectors and payers, and to oversee progress toward cost containment goals.
- *Quality of care, access to care, and patient experience*, stratified by key demographic variables.
- *Provider participation rates*, to determine if providers are declining to participate in the insurance segments that are applying rate caps. In **Washington State**, for example, the public option has had [difficulty securing hospital participation](#). To avoid being subject to out-of-network caps, providers could theoretically reject insurance participation entirely.
- Compliance with cap requirements, by reviewing spending data and insurer-provider contracts.

Step 7. Identify and secure the analytic resources needed.

States should consider what resources they have or will need to develop to carry out a number of analytic functions, including the following:

Analysis of price variation and health care spending in the current health care system. States need this data to focus price caps on areas where there is the greatest potential to achieve the state's goals. These may be areas of high prices, high spending, or high spending growth, as well as areas where there is substantial variation in prices that doesn't correlate with quality. This data will support the state in designing its program, and it is also important for engaging with stakeholders and building a clear and compelling case for why caps are needed.

Defining at what level the cap should be set. States should analyze information about current prices by provider and by service category (for example, hospital inpatient, hospital outpatient, professional services). States will also want to closely examine the financial health of hospitals, including patient revenue by payer, payer mix, and operating and total margins. NASHP's [Hospital Cost Tool](#) can provide an estimate of a hospital's break-even point. States should also plan to model the impacts of potential caps on the affected providers, consumers, and purchasers, paying close attention to providers' financial stability, accessibility, and quality.

Monitoring program effects and adverse effects. After price caps are implemented, the state should be prepared to monitor the financial health of affected provider organizations, consumer access to needed care, care quality, spending, and prices.

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

Bringing down the cost of health care can make it more affordable and accessible to underserved and low-income people, which can improve health equity. When designing price caps, state policymakers should consider two distinct dimensions to equity: equity as it pertains to providers and equity for residents.

Equity among providers. This strategy improves payment equity by addressing the providers that can command the highest rates. When designing provider caps, states should consider whether there are specific institutions that may face particular sustainability challenges at the capped rate levels. These could include, for example, small rural hospitals, or hospitals that have an "unfavorable" payer mix, including a high proportion of uncompensated care. States could consider exempting certain hospitals from

the cap, as **Montana** did for its Critical Access Hospitals. On a positive note, rate floors could potentially protect providers who are unable to command high rates.

Health equity for residents. States should ensure that historically marginalized communities are represented and engaged in the design, implementation, and monitoring of the program. And states will need to monitor programs carefully to ensure there is sufficient access to providers and high-quality care, particularly for such communities. As noted earlier, states should pay particular attention to the financial sustainability of providers, particularly those serving historically underresourced communities, and to the overall quality of care.

Step 9. Engage stakeholders throughout design, implementation, and evaluation.

Communicating effectively with the public about the rationale and goals for a price cap program throughout its development and implementation will be important to the program's success. It will also be important for overcoming near-certain provider opposition. The first step in a comprehensive communication plan is to clearly define and illustrate the problem of high health care costs, especially high provider prices. It is essential that the public understands and recognizes the problem to successfully implement a solution in the face of provider opposition. Multiple modes of communication could be used in this phase and continued throughout implementation, including town hall meetings, earned media, website postings, and social media.

The state should consider establishing structures to engage stakeholders as it designs, implements, and monitors the program. For example, as part of establishing the **Colorado Option program**, the state is undertaking a robust stakeholder involvement process that includes working with consumer groups and community organizations, providing Spanish and ASL translation at meetings, and holding public meetings after business hours to allow for broader participation.

Especially if a state is pursuing price caps in only a subset of its market (for example, public purchaser programs), it will be important for the state to think about opportunities to partner with other payers and with other government entities that have leverage with providers. This will improve their ability to influence provider participation.

Finally, sustaining momentum and support for the program will require states to cultivate champions and partners within the administration, legislature, and broader stakeholder community.

Conclusion

Pursuing provider price caps is not for the faint of heart. Success requires careful analytic and stakeholder work to lay the foundation, develop smart and strategic policies, and foster strong political will to overcome anticipated provider opposition. But the payoff can be significant: improved affordability for consumers and businesses, and the potential for a more functional, transparent market.

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