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

A Hamilton Project proposal by Michael Chernew of Harvard Medical School, Leemore Dafny of Harvard Business School, and Maximilian Pany of Harvard University argues that high and rising commercial prices for health-care services pose a core policy challenge. To address these high and variable prices, the authors propose a three-pronged approach for addressing the highest health-care prices.

Specifically, Chernew, Dafny, and Pany propose a set of regulations to efficiently curb the harms associated with market failures in health-care markets. Their proposal would:

- **Cap market- and service-specific prices** to limit prices at the very top of the commercial price distribution.
- **Cap price growth at the service-insurer-provider level** to constrain price inflation.
- **Implement flexible regulatory oversight** by state and/or federal authorities to address potential evasion of the caps.

Issue Overview

- **U.S. health-care spending—which is higher than in any other advanced economy**—is driven mostly by higher prices, with little evidence to suggest that U.S. high prices reflect better quality of care.
- **There is limited cost-reduction potential from tools that enhance price transparency,** including patient price shopping tools, high deductibles, tiered networks, and referencing pricing.
- **High and variable prices reflect market failures that can only be partially addressed through pro-competitive measures.** As such, the authors propose a set of regulations to curb the harms associated with market failures in provider markets.

The Challenge

The United States spends a larger share of its GDP on health care—and faces higher health-care prices—than other advanced economies. These prices vary substantially across markets, across providers within markets, and even within providers across insurance contracts.

Some portion of these high and variable prices reflects natural differences in market-specific resource costs (e.g., wages or rents), production efficiency, and perhaps health-care quality. However, a significant portion reflects market power and market failures. A key challenge to addressing high and rising health-care prices lies in eliminating the component of high prices that is due to imperfect markets while preserving market functioning.

The Path Forward

Chernew, Dafny, and Pany discuss how price regulations could be used to constrain the highest and fastest-growing commercial provider prices. Their proposal would:

- **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 for a given local market.** 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.
    - **Determine price caps based on commercial prices, not Medicare rates.** Although imperfect, using commercial prices as a basis for price caps has advantages relative to Medicare fee schedules. The authors' caps are more flexible over time, reflect the relevant service and patient mix, and allow for prices to more easily adjust for productivity gains.
    - **Base the price cap on a multiple of a low percentile of the distribution, rather than base the cap on a high percentile.** This has several benefits: it will be less distorted by market power at the top of the distribution, 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, and it allows room to provide higher quality.
- **Place an annual cap on service-, insurer-, and provider-specific price growth, varying inversely with provider price**. Over time, such a growth-rate cap will likely induce greater convergence of prices across providers but would 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 that market power is not being exercised through payments outside of the fee-for-service system.

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.

About the Authors

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