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Two Approaches To Capping Health Care Prices

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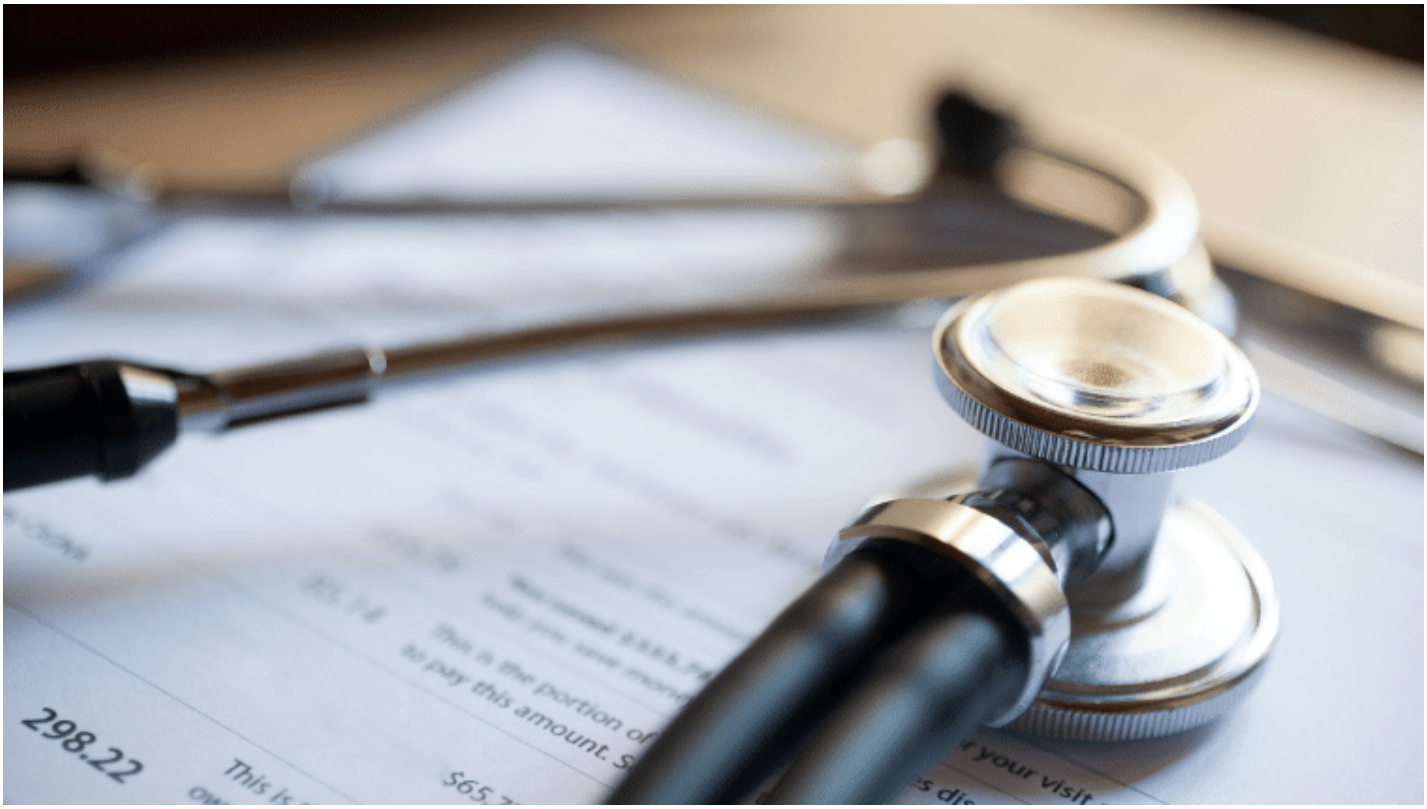

Prices for health care services in the commercial sector in the US are high and vary widely within and across geographic markets. High prices contribute to high premiums, which put downward pressure on wages, and induce employers to reduce benefit generosity and charge employees more for coverage. As the average annual premium for family coverage currently exceeds $22,000, many US states are interested in

policies that would lower prices for care. The appropriate regulatory reaction to high provider prices depends on the underlying reasons for high prices. One concern about price regulation is the possibility that it will prevent providers from delivering excellent care, care for which at least some of the population is willing and able to pay. For example, if today's high prices reflect high quality or unobserved costs, proposed policies that substitute lower, regulated prices for market-based commercial prices may unduly diminish quality or access.

While some higher-priced providers (that is, hospitals, other facilities, and physicians) may offer higher-quality care, this relationship may not be causal and thus does not imply price caps will lower quality. For example, there is ample research showing that the hospital industry has consolidated over the past few decades, and that this consolidation has led to price increases without measurable quality improvements. Similarly, the growth in physician fees due to surprise billing is unlikely to drive higher quality. Thus, there may be some room to lower price levels or price growth without adverse quality consequences.

Here, we discuss two strategies to limit health care prices: comprehensive price caps supported by rate review and out-of-network price caps. These strategies can be applied to all services or just a subset, but the core issue—whether regulation should be comprehensive (for example, apply to both in-network and out-of-network care) or only focused on out-of-network care—is similar regardless of the set of services regulated. Both strategies have three key advantages over alternatives such as price-setting: They can preserve a meaningful role for market forces; they minimize disruption to health care markets; and they can be adjusted more easily than other approaches as evidence of their impact emerges.

Comprehensive Price Caps

Comprehensive price caps are a regulatory system that sets the maximum prices that providers can charge for both in-network and out-of-network care. Such a system can be defined granularly (for example, service by service) or actuarially for a book of business (for example, average dollars per unit of service). In the granular approach, the cap for each current procedural terminology (CPT) or diagnosis-related group (DRG) code could be determined using either market-based or administratively set prices.

For example, in earlier work we have suggested capping the maximum price of a specific service at five times the 20th percentile of price in the relevant market (and capping this figure at the 75th percentile nationally). Alternatively, the cap could be a multiple of Medicare prices. Using Medicare as the basis for the cap presents fewer data requirements and is not subject to variation due to sampling because claims data are not needed. However, a Medicare-based price cap will transmit any price effects of policy actions related to Medicare—such as the sequester, Affordable Care Act productivity adjustment, subinflation physician fee increases, and site-based pricing differentials—to commercial markets. Moreover, Medicare-based price caps, if widely used, may also complicate Medicare policy making because the stakes associated with any change in Medicare fees would be greater (since they are multiplied by their impact on commercial markets) and thus may attract more stakeholder attention.

An actuarial approach that applies a price cap broadly across services instead of service by service (for example, capping, within each insurer-provider contract, average price charged per relative value unit or per DRG) offers some advantages. Specifically, if the basis for the price cap is a low percentile of commercial rates, the actuarial approach may overcome data problems associated with small sample sizes for rare services. The actuarial approach can also surmount data problems related to alternative payment models (APMs) or efforts to circumvent the regulations with payments outside of the claims system (for example, quality or APM bonuses or infrastructure payments). With this approach, compared to the granular approach, regulators do not need to focus as much on the form of payment (for example, whether and which services are bundled for payment). In addition, the actuarial approach can address the concern that Medicare pays for outpatient services using a broader payment unit that includes groups of diagnostic codes (that is, ambulatory payment classifications) compared to most commercial plans, which often use more granular CPT codes.

Because the price caps may affect only a small number of providers (although this could be modified by lowering the caps), a complementary approach is to cap price growth. Price growth caps can also guard against the concern that the caps will serve as a sentinel price, leading providers to increase prices to reach the cap.

Some of the same issues that arise when capping price levels arise when capping price growth, and a decision must be made regarding whether to pursue a granular or an

actuarial approach. If price growth is capped, it is likely that the growth cap will need to vary based on initial price levels (that is, more stringent caps for high-price providers and more generous caps for low-price providers) to avoid locking in high prices and wide price differentials.

Given the complexities of implementing comprehensive price caps (or price growth caps) and analytic requirements if an actuarial approach is used, a comprehensive price cap system will require an effective regulatory infrastructure. This infrastructure could build on existing state premium rate review activities with additional resources as needed. Although different across states, rate review generally refers to a system in which a state department of insurance reviews insurance premiums and refrains from approving those with excessive or unjustified increases (or conversely, rates that are so low that they threaten an insurer's solvency). Rate review may be more effective if combined with comprehensive price regulation that sets explicit limits on prices, although the effort and resources required will vary across states, and the implementation cost need to be considered.

Out-Of-Network Price Caps

An alternative to comprehensive price caps is out-of-network price caps. In many ways, this is administratively easier because, by definition, there is no contract defining how out-of-network providers are paid nor payments outside of the claims system (for example, quality bonuses). For this reason, the Medicare fee schedule can be used as the basis for out-of-network price caps without causing the same degrees of pressure on the Medicare fee schedule that is likely to arise under comprehensive price caps, where this fee schedule would then impact both in- and out-of-network prices. Relying on fee schedules rather than data-derived values (for example, median in-network prices for a given insurer and unit of service) is easier to implement because service definition and the associated price are publicly defined, and commercial prices could be used if available. Regulating out-of-network prices (rather than all prices) enables flexibility for high-quality providers to negotiate above-cap prices (or alternative payment approaches) if they come in network.

The impact of out-of-network price regulation hinges crucially on the extent to which out-of-network prices influence negotiations for in-network prices. Limiting the ability of providers to set high out-of-network prices shifts negotiating leverage toward insurers. Regulated out-of-network prices can have dramatic effects. In Medicare Advantage, for example, where the out-of-network price reverts to the Medicare price, in-network prices

typically approximate Medicare prices.

Yet, this outcome is not guaranteed. If providers can impede access or deny service to out-of-network patients, they may still exercise market power and negotiate high in-network prices, even if the out-of-network cap is stringent. Employers may demand that popular, high-price providers be brought in network to guarantee acceptable access for their employees and dependents. If the insurance market is competitive, an insurer that excludes popular providers from the market may lose market share even if that insurer offers a lower premium. In fact, even in the Medicare Advantage market, the out-of-network price does not guarantee that Medicare Advantage plans will pay prices close to Medicare rates. For example, Medicare Advantage prices for dialysis, a service in which providers have significant market power, tend to be above Medicare fee-for-service rates.

Conclusion

While we generally support market mechanisms to allocate resources, we believe the failures in health care markets are sufficiently large and concerning that government regulation is needed. Here, we have discussed two options: comprehensive price caps and out-of-network price caps. These interventions can be dialed up or down based on evidence and policy preferences, and they balance the need to address market failures while still preserving a sizeable role for market forces.

Comprehensive price caps can be supported by well-resourced and empowered state rate review agencies and serve as a tool for policy makers to reduce the highest prices in the market, thereby countering some of the deleterious consequences from past industry consolidation. Such a system can be broad and flexible enough to have a meaningful impact with minimal disruption. Rhode Island has used a similar approach to enforce price growth caps, and early evidence of its impact is promising.

Alternatively, many of the benefits of comprehensive price regulation may be achieved by limiting regulation to out-of-network prices, and out-of-network-only regulation would require less regulatory oversight. Such a system can influence in-network prices without the need to directly observe those prices or other financial transactions between payers

and in-network providers. However, the extent to which out-of-network price regulation will impact in-network prices is unknown and likely context dependent.

While these are not the only policies that could address high prices and premiums in the commercial market, and significant implementation hurdles must be overcome to make either option a reality, they offer a reasonable path forward to address an important and growing problem in the US health care system. Which to pursue—if either—depends on policy maker preferences, implementation costs, and assessments regarding the ability of regulators to modify their processes as the evidence of impact emerges.

Authors' Note

Leemore Dafny has served as a consultant and litigation expert on matters in the hospital and health insurance sectors and has received compensation from the Center for Equitable Growth, Brookings Institution, Cornerstone Research, Analysis Group, Bates White Economic Consulting, and Intermountain Healthcare. She serves on paid boards for the Congressional Budget Office (panel of health advisers). Maximilian Pany received a training grant from the National Institute on Aging (Grant No. T32AG51108) and has received compensation from the Brookings Institution. Michael Chernew has research grants from Blue Cross Blue Shield Association, Health Care Service Corporation, Ballad Health, Signify Health, LLC; received personal fees from Blue Cross Blue Shield of Florida, Humana, and America's Health Insurance Plans; and has equity in Archway Health and Waymark, Inc. Dafny serves as an unpaid advisory and in editorial roles for the Commonwealth Fund, Management Science, and *American Economic Journal: Economic Policy*. Pany serves on the board of trustees of the Massachusetts Medical Society (unpaid). Chernew serves on advisory boards for National Institute for Health Care Management, Blue Cross Blue Shield Association; and serves as the current chair of Medicare Payment Advisory Commission.

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