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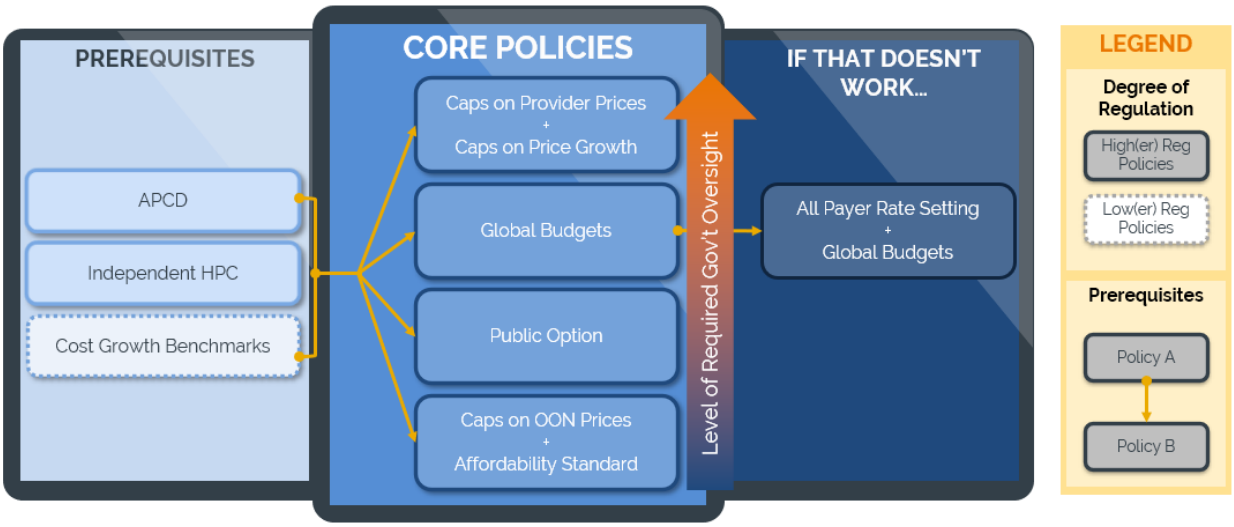
Issue Brief #5
Regulate Provider Prices

WHY SHOULD STATES CONSIDER THIS MENU?

As market-based interventions have provided insufficient relief from rising commercial health care costs, states have a unique and pressing opportunity to enact policies that place downward pressure on unit prices and rebalance market power toward health care purchasers and consumers. The geographic, political, and economic diversity across the 50 United States opens possibilities for state governments to shape their own policy agendas; however, states will likely find that a single piece of legislation proves insufficient to deliver meaningful relief, and/or will create vulnerabilities that are easily exploited by stakeholders who benefit from the status quo. It is therefore recommended that state legislators consider *combinations* or *menus* of policy options to create complementary infrastructure, close loopholes and plan for contingencies.

This issue brief, the fifth of six in the series, offers options for state governments considering direct regulation of health care prices. For some states, particularly those experiencing high prices, consolidation, and which have a higher tolerance for government intervention, the most viable path toward improving health care affordability may lie in exerting direct control. This is not to say that the only option on the table is for states to set uniform prices for all payers and services (i.e., all-payer rate setting). States may establish price caps and apply controls to select sites of service, markets or circumstances. By placing a strategic clamp on health care prices, policymakers and regulators attempt to create an environment where negotiations between payers and providers proceed on a more even playing field. This menu describes a spectrum of options, organized by the level of government oversight required; as with previous issue briefs, the menu describes prerequisite infrastructure and options for further intervention if the core policies fall short of desired results.

The core policies in this menu, along with their prerequisites and alternative next steps, are listed in the figure below.



PREREQUISITE POLICIES

Regulating provider prices requires a steady stream of reliable data and a group of uncompromised experts to analyze, interpret, course correct, and hold stakeholders accountable for outcomes. As such, all price regulation policies described in this menu require the following infrastructure:

1 All Payer Claims Database (APCD).

APCDs collect medical claims data from multiple sources including private health insurers, public insurers like Medicaid and Medicare, prescription drug plans, dental plans, and self-insured employer plans. As such, APCDs provide a mechanism for states to monitor quality, utilization trends and cost within their health care markets, especially because they include actual paid amounts—not charged amounts—which reflect the negotiated rates between payers and providers. Any policy intervention that requires the state to set price caps, total cost of care targets, or sets specific service prices, will need data from an APCD to calibrate targets and measure the impact.

2. Health Policy Commission (HPC)

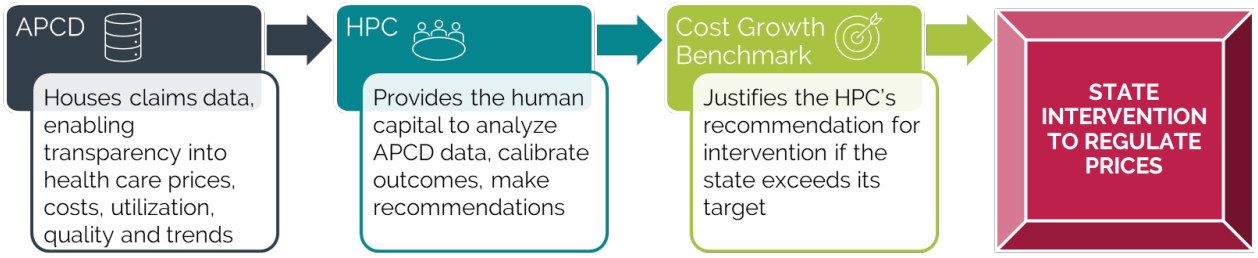
The information contained in an APCD has little utility without a designated body to analyze and interpret the data and offer recommendations in response.[1] This is why several states, in addition to APCDs, established HPCs, usually and advisably as independent agencies that provides legitimacy and credibility among a broad array of stakeholders. In the context of price regulation, an HPC can provide analysis of prices, utilization, quality and trends, and use these insights to calibrate benchmarks and advise the state on where and how it should regulate provider prices.

[1] Note that in some states, entities other than the HPC are responsible for analyzing APCD data; data analysis need not be housed within an HPC.

3. Cost Growth Benchmarks

Cost growth benchmarks, also known as cost growth *targets,* establish state-issued goals for health care spend and spend growth. By themselves, these targets are symbolic, but they provide a crucial *forcing mechanism,* justifying state intervention in the commercial market.

The interplay between these three prerequisites is summarized in the graphic below:



CORE POLICIES

Listed by the level of government oversight required.

1. Caps on Out-of-Network Prices + Affordability Standard

Capping out of network (OON) prices offers an avenue for states to moderate commercial prices without regulating the market directly. This approach not only truncates high prices paid on an OON basis; it also protects consumers from balance bills and could compel lower in-network commercial prices. The spillover effect on in-network prices occurs because capping OON prices de-fangs providers' negotiating trump card: the threat of going out of network if health plans won't accommodate their demands. Today, if a provider decides to dissolve its contracts with a health plan, it can compensate for lost revenue and volume by charging OON prices that are on par with its billed charges rate (sometimes upwards of 500% of Medicare).[2] Capping out-of-network prices compels providers to stay at the negotiating table, and what's more, gives health plans the leverage to price their in-network rates on par with the OON cap.

It is advisable to pair a cap on OON prices with an *affordability standard* for health care premiums. An affordability standard limits the rates and rate growth of health plan premiums (like a cost growth benchmark but aimed at health plans instead of providers). Pairing an OON price cap with an affordability standard prevents health plans from pocketing the profits that accrue from the effects of the OON price caps.[3]

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[2] Murray, R. and Keane, J. (2022). "Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall." The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2022/may/setting-caps-out-of-network-hospital-payments

[3] Although medical loss ratios (MLRs) allegedly prevent health plans from this type of profiteering, many economists believe that carriers frequently game the MLR system by paying providers unwarranted bonuses, or claiming expenses as "quality improvement," in an effort to keep premium rates and revenue high. See: Hansard, S. (2022). "Insurers' 'Gaming' of Obamacare Provision Seen Boosting Premiums." Bloomberg News. https://news.bloomberglaw.com/employee-benefits/insurers-gaming-of-obamacare-provision-seen-boosting-premiums

2. Public Option

A state public option plan is a state-sponsored health insurance plan that sets provider prices and is offered to the commercial health insurance market. Public option plans can potentially lower health care costs by deploying the state's heft and influence to negotiate lower prices for health care services and prescription drugs. What's more, if the state can successfully administer a plan with premiums that are lower than what commercial plans offer, a public option can place downward pressure on commercial plan premiums, as private health plans are compelled to compete with the government's negotiated rates.[4]

While there are multiple ways to construct a public option, the flavors of state-sponsored plans generally fall into three categories:

- *Medicaid Buy-in Plans*, wherein the state either requires managed care organizations (MCOs) to offer their Medicaid plans to non-Medicaid eligible populations or the state can leverage its own Medicaid agency infrastructure to administer its own public option plan.
- *Market-based Public Option (MBPO)*, under which the state issues its own ACA-compliant plan on the public or private individual exchanges.
- *Comprehensive Public Option*, a health plan that the state administers and offers to all commercial market segments, including individuals currently covered by employer-sponsored insurance.

Beyond selecting the type of public option plan to pursue, the state must also determine which market segments its health plan will cover, whether the state will administer the plan itself or outsource operations to the private sector, how the plan will be financed, and how to contend with the potential disruption to the provider and health insurance markets. To date, the three states that have launched public option plans are Washington, Colorado and Nevada. All three states' public option plans follow the MBPO model; while several states have proposed legislation for Medicaid buy-in plans and comprehensive public options, none has successfully passed their proposals into law.

3. Global Budgets

Hospital global budgets establish inpatient and outpatient spending maximums for health care facilities as an incentive to reduce low-value services and rein in costs. Even though economists consistently find that prices (not utilization) typically drive health care spend, when states set facility prices, hospitals may compensate by increasing volume, or raising prices in non-regulated sites of service.[5] Establishing a revenue limit through a global budget provides a full backstop against excessive hospital expenditure growth.

Implementing global budgets at scale requires the state to set annual targets for each hospital based on historic revenue and utilization, patient population demographics, and uncompensated care. Under a fixed global budget model, each hospital receives a prospectively determined amount for all of the services it provides in a given year; however,

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[4] King, J. S., Gudiksen, K. L., and Fuse Brown, E. C. (2022). "Are Public Options Worth It?" Harvard Journal on Legislation. https://harvardjol.com/wp-content/uploads/sites/17/2022/03/104_King-et-al.pdf

[5] Anderson, G., and Herring, B. (2015). "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs." AMA Journal of Ethics, 17(8), 770–775. https://doi.org/10.1001/journalofethics.2015.17.8.pfor1-1508

the problem with this approach (which has plagued Canada and many European countries) is that it provides incentives for hospitals to ration care and removes the incentive for hospitals to compete for market share. To solve for this externality, states may prefer to create a variable budget model for hospitals. Under this approach, hospitals still receive an annual budget, but the budget target can be adjusted depending on the variable costs of excess patient volume. States may ratchet the revenue targets up or down depending on the hospital's performance on quality metrics and efficiency.

In the past, states tended to launch global budget programs in rural or isolated markets that have well-defined patient populations and more predictable annual spend. However, hospital global budget models can be implemented for all or most hospitals in a state or given region as evidenced by the Maryland hospital global budget demonstration and past Medicare global budget demonstrations such as the Rochester Hospital Experimental Payment Program.

4. Caps on Provider Prices/Provider Price Growth

The fact that 2/3 of health care cost inflation is driven by price, not utilization, begs the obvious question: why not attack the problem at its source by capping commercial prices? Capping provider prices offers a softer touch than setting them: the state government dictates a maximum price for services to rein in outliers while allowing the remainder of the market to function as it will. Some experts advocate for coupling this policy with caps on price increases to prevent providers from rapidly escalating to the maximum. However, while a provider price cap only impacts providers on the far-right tail of the price distribution bell curve, a cap on price increases will impact providers across the board. In either case, by adopting this regulatory approach, policymakers must determine what source to use as a benchmark for provider prices and select a methodology for calibrating the maximum. Three benchmarking options with their benefits and tradeoffs are summarized in the table below:

Benchmark Source	Benefit(s)	Tradeoff(s)
Medicare Prices: set cap at multiples of Medicare rates	**Simplicity:** Medicare has already set prices for most hospital services	**Baked-in Defects:** carries over Medicare pricing distortions; Medicare does not cover all services
Service-level Commercial Prices: plot the distribution of commercial service-level prices locally; set cap at a multiple of percentile rates.[6]	**Avoids Medicare's flaws:** i.e., price distortions and lack of benchmarks for non-covered services	**Complexity:** establishing service-level price distributions across multiple localities requires significant, granular data and analysis; may be subject to sampling error

[6] Chernew, Dafny et al. recommend setting the cap at 5 x the 20th percentile, see: Chernew, M. E., Leemore, D. S., and Pany, M. J. (2020). "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market." The Hamilton Project. https://www.hamiltonproject.org/papers/a_proposal_to_cap_provider_prices_and_price_growth_in_the_commercial_health_care_market

Relative Value Units (RVUs) or Diagnostic Related Groups (DRGs): calculate the distribution of local commercial prices for RVUs or DRG-weighted inpatient care;[7] set cap at a multiple of percentile rates.	**Relative simplicity:** unburdens the state from plotting every service-level price locally by using standardized units of pricing across all services	**Relative complexity:** still requires significant data and analytic resources

It's important to point out that no matter how the state formulates a commercial price cap, this policy exerts a greater degree of state control over provider prices than the strategies that precede it, and consequently requires considerable effort and resources to enforce and sustain it.

IF THAT DOESN'T WORK…

If these efforts fail, states can take an even more comprehensive approach to regulating the market by setting prices directly for all payers and pairing the prices with hospital revenue targets.

All Payer Rate Setting + Global Budgets

Through all-payer rate setting, the state establishes its own singular fee schedule that applies to commercial prices along with Medicare and Medicaid. Because rates apply to federally funded programs as well as commercial populations, all-payer rate setting requires states to apply for a federal waiver. It also requires states to establish regulatory infrastructure to set prices and monitor spending.

As noted earlier, since total cost of care is the product of price and quantity, constraining prices leaves the door open for the delivery system to compensate by increasing service volume or shifting volume to sites of services where the all-payer rate doesn't apply (e.g., outpatient settings or physician offices). Closing this loophole requires the state to constrain total hospital revenue. This was the case in Maryland, the only state that currently has an all-payer rate in place. While the all-payer rate significantly reduced spending per hospital admission, the state saw increases in service volumes that increased total cost of care.[8] In response, Maryland introduced global budgets and incentives for population health management and quality improvement.[9]

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[7] Adjusting for differences across sites and the role of facility fees

[8] Anderson, G., and Herring, B. (2015). "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs." AMA Journal of Ethics, 17(8), 770–775. https://doi.org/10.1001/journalofethics.2015.17.8.pfor1-1508.

[9] Murray, R. and Berenson, R. (2015). "Hospital Rate Setting Revisited." The Urban Institute. https://www.urban.org/research/publication/hospital-rate-setting-revisited-dumb-price-fixing-or-smart-solution-provider-pricing-power-and-delivery-reform

CONCLUDING THOUGHTS

Regulating provider prices does not necessitate a full state government takeover of the health care marketplace. As shown in this menu, states have options as to where, how, and to what extent they intervene. All regulatory policies discussed here require infrastructure and oversight (to varying degrees) and should be coupled with a forcing mechanism like a cost growth benchmark to justify intervention and escalation. The required resources and political capital to execute is high, and states should enter this arena with eyes open and be prepared for delivery system pushback.

This evokes one final caveat: regulatory capture. Regulatory capture occurs when the agencies or entities charged with industry oversight become beholden to industry interests. As states attempt to balance the interests of the health care delivery system with the needs of payers, purchasers and plan members, they must position themselves as an ally of the delivery system, but also as its watchdog.

RECOMMENDED SUPPLEMENTARY READINGS

CPR's white paper, Combinations of State-Based Health Care Policies to Constrain Commercial Prices and Rebalance Market Power, contains an insert that describes all policies discussed in this issue brief in greater detail. This research is available to the public at no cost. Additional source materials for deeper dives into the policies described here are provided below.

Caps on Out-of-Network Prices + Affordability Standard

- Murray, R. and Keane, J. (2022). "Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall." The Commonwealth Fund.
- Rakotoniaina, A. (2021). "How Oregon is Limiting Hospital Payments and Cost Growth For State Employee Health Plans." National Academy for State Health Policy.
- NCSL staff. (2016). "State Approval of Health Insurance Rate Increases: States with Effective Rate Review Programs." National Conference of State Legislatures.

Public Option

- King, J. S., Gudiksen, K. L., and Fuse Brown, E. C. (2022). "Are Public Options Worth It?" Harvard Journal on Legislation.
- Blumberg, L. et al. (2020). "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets," The Urban Institute.
- Fuse Brown, E. C., Gudiksen, K. L. and King, J. S. (2021) "State Public Option Plans — Too Modest to Improve Affordability? New Englad Journal of Medicine

Global Budget

- Murray, R. (2022). "Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending," The Commonwealth Fund.
- Morrison et al. (2021). "Impacts of Maryland's Global Budgets on Medicare and Commercial Spending and Utilization." Medical Care Research and Review: MCRR, 78(6), 725–735.
- Roberts et al. (2018). "Changes in Health Care Use Associated with the Introduction of Hospital Global Budgets in Maryland," Jama Internal Medicine, 178(2):260-268.

Caps on Provider Prices/Provider Price Growth

- Chernew, M. E., Leemore, D. S., and Pany, M. J. (2020). "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market." The Hamilton Project.
- Chernew, M. E., Leemore, D. S., and Pany, M.J. (2022). "Two Approaches to Capping Health Care Prices." Health Affairs.

All-Payer Rate Setting

- Murray, R. and Berenson, R. (2015). "Hospital Rate Setting Revisited." The Urban Institute.
- Anderson, G., and Herring, B. (2015). "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs." AMA Journal of Ethics, 17(8), 770–775.
- Haber, Susan, et al. (2018). "Evaluation of the Maryland All-Payer Model,"

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is an independent, 501c3 nonprofit corporation on a mission
to catalyze employers, public purchasers, and others
to implement strategies that produce higher value health care
and improve the functioning of the health care marketplace.

This research was made possible by
the support of Arnold Ventures