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The Price Isn't Right: Strategies to Address High and Rising Healthcare Prices

When U.S. healthcare prices are compared to those in other countries or when healthcare price growth is compared to the growth of non-healthcare commodities, there is general agreement that prices seem excessive. Early efforts to quantify excessive prices stem from the Institute of Medicine's identification of "pricing failures" as a category of healthcare waste, which occur when the price of a product or service exceeds "the cost of production plus a reasonable profit."¹ Using this definition, researchers estimate that excess prices drive \$230-\$240 billion in wasteful healthcare spending each year (as of 2019).²

The evidence is clear that year-over-year increases in the *prices* of healthcare services—not the number of services provided—is the primary driver of high annual healthcare spending growth. High spending growth is most prevalent in the commercial insurance market and,

particularly, for payments related to outpatient hospital services and prescription drugs.³

States, in their role as regulators and payers, and commercial insurers are important actors that can help keep healthcare prices in check. Evidence-based strategies available to these actors—depending on the market power of local providers—are described in this report.

The Role of Concentrated Markets

Competition—or lack thereof—plays a large role in determining how much providers, drug companies and device manufacturers can charge for their products and services. It also affects the set of solutions that are available for states and commercial payers to address high and rising unit prices.

Over the past several years, consolidation through mergers and acquisitions has increased providers' market power and strengthened their ability to negotiate higher prices in their contracts with payers, regardless of the quality of care they provide. A 2016 Federal Trade Commission report found that hospitals that held monopolies charged 15 percent more than those with four or more competitors. Hospitals with one or two competitors charged 5-6 percent more than those with four or more competitors.⁴

Similarly, drug manufacturers have been accused of charging exorbitant prices for drugs when competition is limited.⁵ Studies show that the prices of brand name drugs decline to nearly half their original cost after two generics enter the market, and a third of their original cost once five generics enter the market.⁶

Public scrutiny and concern over market domination have increased in recent years in response to growing evidence of anti-competitive and anti-consumer business practices,⁷ in addition to widespread affordability problems creating barriers to coverage and care.⁸

SUMMARY

When U.S. healthcare prices are compared to those in other countries or when healthcare price growth is compared to the growth of non-healthcare commodities, there is general agreement that prices seem excessive. The evidence is clear that year-over-year increases in the *prices* of healthcare services—not the number of services provided—is the primary driver of high annual healthcare spending growth. States, in their role as regulators and payers, and commercial insurers are important actors that can help keep healthcare prices in check. Evidence-based strategies available to these actors—depending on the market power of local providers—are described in this report.

Strategies to Address High Prices When Provider/Product Competition Exists

Certain forms of price transparency—like peer comparisons and reference pricing—can lower prices when there are multiple competitors in a market. These strategies are effective because they single out high-priced providers, incentivizing them to lower their prices to better align with their competitors.

Peer Comparisons

Provider “peer comparisons” are commonly employed to control unnecessary utilization, but anecdotal evidence suggests that they can motivate high-cost providers to lower their prices as well.⁹ Prior to 2010, payments to New Hampshire’s most expensive hospital exceeded those of its competitors by nearly 50 percent. The state’s largest insurer had been unable to decrease prices due to the hospital’s prominent reputation and loyal patient base, however, evidence of excessive prices—made public on the state’s price transparency website—enabled the insurer to brand the hospital as a pricing outlier, garner public support and negotiate lower prices. Market observers testified that, despite limited public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state’s insurers and narrowed price variation over time.¹⁰

Reference Pricing

Reference pricing strives to contain healthcare costs by establishing a “reference price” that a payer will contribute towards the cost of a certain procedure. Patients are free to select their desired provider but are required to pay expenses in excess of the established amount. While the primary goal is to incentivize patients to seek care from lower- to moderately-priced providers, a now famous study from the California Public Employees’ Retirement System (CalPERS) showed that high-priced providers of knee and hip replacement surgeries lowered their prices to meet the established rate in order to remain competitive.¹¹

Public and private payers can increase the likelihood that the strategy will lower prices by focusing on

procedures that are routine, elective and non-urgent; are offered by many providers; have high variation in prices; have little variation in quality; and are widely identified as the appropriate mode of treatment for a particular condition.¹² Additionally, resources should be provided to ensure that patients can easily locate high-quality providers meeting the reference price.

A potential limitation is that reference pricing—like other forms of price transparency—could cause low-price providers to raise their prices to meet the market rate. However, this phenomenon has not been widely observed.¹³

While consumer-facing price transparency tools help keep consumers safe in the market by allowing them to plan ahead for a medical expense, they have not been shown to put downward pressure on healthcare prices.

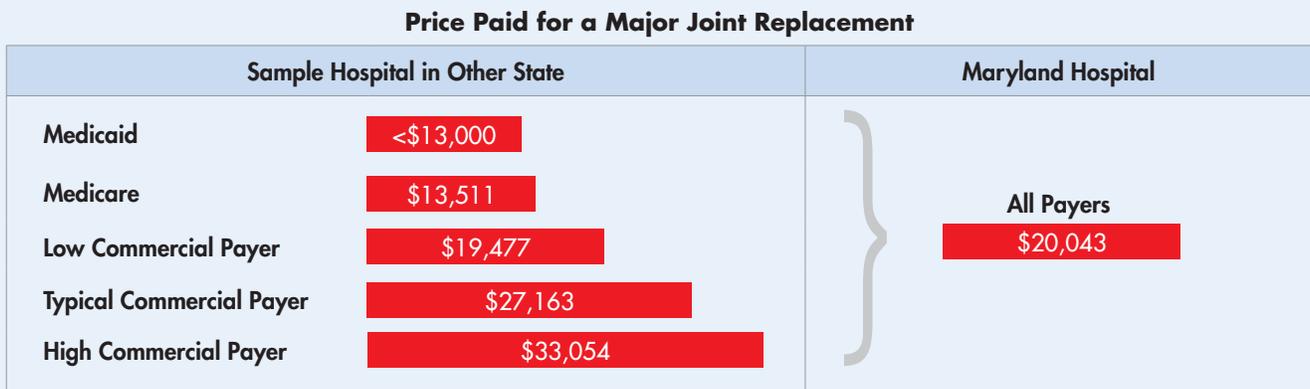
Myth: Consumer-Facing Price Transparency and Payment Reform Suffice to Lower Excess Prices

It is commonly argued that other strategies, such as consumer-facing price transparency and provider payment reform, suffice to lower excess prices. While consumer-facing price transparency tools help keep consumers safe in the market by allowing them to plan ahead for a medical expense, they have not been shown to put downward pressure on healthcare prices.¹⁴ In fact, some patients perceive high prices as a sign of better quality, diluting the effectiveness of this approach.¹⁵ Other factors—like insurance coverage that distances consumers from the cost of their care and trusted relationships between patients and their clinicians—also decrease the likelihood that consumers will make decisions based solely on cost. Similarly, little evidence supports the claim that provider payment reforms, such as pay-for-performance programs, lower healthcare prices. Rather, these programs typically seek to improve quality and/or address utilization problems, with mixed success.¹⁶

Strategy in Action: Maryland’s All-Payer Rate Setting System

Maryland’s hospital rate setting system is the last remaining example of a comprehensive rate setting approach. The state’s Health Services Cost Review Commission sets uniform payment rates for *all payers* operating in the state, thus Medicare, Medicaid and commercial payers pay the same amounts for the services hospitals provide (see Figure 1). While the program has evolved significantly since its inception, studies show that cost per admission was well controlled under the original system. The state’s average cost per admission—26 percent higher than the national average in 1976—was 2 percent lower than the national average by 2007. Maryland experienced the second lowest rate of per-admission cost growth compared to other states during this time.^{24,25}

Figure 1
Hospital Payment Rates: Maryland vs. Other States



Sources: Analysis of 2013 Medicare and commercial hospital payments by CBO (Tables 2 and 5): <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf>. Maryland estimate is the ratio of MD payments to US average from CMS Inpatient Charge Data FY 2014 (found here: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2014.html>)

Additional Considerations

As demonstrated by the New Hampshire example on page 2, the presence of more than one provider in a market may not be enough to create price competition. The same holds true for the pharmaceutical industry, where “shadow pricing” occurs when lower-priced manufacturers increase the price of a drug to align with higher-priced competitors.¹⁷ In these cases, states should look to the next set of solutions—strategies to lower prices when competition is scarce.

Strategies to Address High Prices When Provider/Product Competition Does Not Exist

According to the Commonwealth Fund, approximately 90 percent of provider markets (including hospitals, specialists and primary care physicians) were either

highly or “super” concentrated as of 2017.¹⁸ Given the link between consolidation and higher prices,¹⁹ regulators and payers need solutions that do not rely on the threat of taking business away from a provider or product manufacturer. The following strategies show potential to (1) lower the price of a single service, (2) cap the price of a bundle of services or (3) limit price growth, even in situations when competition is scarce.

Strategies to Lower the Price of Individual Services

Tie Provider Payments to Medicare Rates

Commercial sector prices are often compared to Medicare prices in order to gauge their reasonableness. Although imperfect, Medicare prices are used as a benchmark because the program makes an effort to set prices based on the cost of production, plus a reasonable profit.²⁰

WAYS THAT STATES CAN LIMIT PROVIDER PRICES IN CONSOLIDATED MARKETS	STATES ENACTING
Tie employee benefit plan payments to Medicare rates	MT, OR
All-payer rate setting	MD*
Anti-price gouging legislation	MD (attempted)
Establish global budgets for hospitals	MD, PA
Review and approve hospital budgets	VT
Cap price growth as a condition of mergers/acquisitions	MA, among others
Establish price controls on contracts between commercial insurers and providers	RI
Establish a healthcare cost growth benchmark	MA, VT, DE, RI, OR, CT

* Vermont's Green Mountain Care Board also has the authority to conduct all-payer rate setting but does not currently exercise this authority.

States can leverage their negotiating power as major employers to tie the prices that providers charge state employee health plans to Medicare rates. For example, Montana capped payment for all hospital services at an average of 234 percent of Medicare rates beginning in 2016, saving the state approximately \$15.6 million in the second year of implementation.²¹

Hospital/Physician Rate Setting

Hospital or physician rate setting is a process by which an authority, usually a state agency, establishes uniform rates for hospital or physician services and controls the growth of payment levels over time. Several states—including New York, Massachusetts, New Jersey, Maryland, Washington, Connecticut and West Virginia—experimented with rate setting as a means of controlling healthcare price growth in the 1970s and 1980s, however only Maryland continues the practice today.²²

Despite a decline in popularity, studies show that rate setting is a highly effective means of cost control, particularly when the programs account for volume growth that may develop in response to rate limits. Broad legislation that allows regulators flexibility to design and evolve the system over time; enforcement mechanisms such as penalties for non-compliance; and support from a broad coalition of stakeholders also contribute to the initiatives' success.²³

Anti-Price Gouging Legislation

Pharmaceutical manufacturers and pharmacy benefit managers have come under fire for various practices that stifle competition and raise prices.²⁶ In recent years, several states have introduced legislation to prevent harmful, and even unethical, activities such as “price-gouging”—when a manufacturer uses its competitive advantage to charge unreasonably high prices for “essential off-patent or generic drugs.” In May 2017, Maryland became the first state to pass such legislation (applicable only to generic drugs), which was struck down on constitutional grounds.²⁷ In 2019, the U.S. Supreme Court declined to consider the Maryland Attorney General's appeal. No other state has passed similar legislation as of 2020.

Strategies to Cap the Price of a Bundle of Services

Global Budgets

Global budgets are a payment model in which providers—typically hospitals—are paid a prospectively set, fixed amount for the total number of inpatient, outpatient and emergency services provided annually. Hospitals are responsible for expenditures in excess of the set amount in addition to quality outcomes, thus creating an incentive to reduce unnecessary utilization and invest in prevention.

Maryland has incorporated global budgets into its long-running all-payer rate setting program with notable success.²⁸ A 2019 evaluation showed that “the model reduced hospital costs [to the Medicare program] without shifting costs to other parts of the Maryland healthcare system outside the global budgets,” producing \$975 million in savings to the Medicare program compared to a control group. Hospital expenditures for commercially insured patients also grew more slowly than the control group, however, the savings were offset by increased spending on professional services.²⁹

Other states, like Pennsylvania, are now testing global budgets’ effectiveness in a non-rate setting environment. Pennsylvania’s plan differs from Maryland’s in that it focuses exclusively on rural hospitals, which generally face limited competition due to provider shortages. As of late 2020, the Pennsylvania Rural Health Model has yet to be evaluated.³⁰

Strategies to Limit Price Growth

Review and Approve Hospital Budgets

Vermont’s legislature charged the Green Mountain Care Board (GMCB) with reviewing and approving hospital budgets as a mechanism to slow healthcare cost growth in 2012. Each year, the GMCB sets growth targets limiting the rate that hospitals’ net patient revenue, chargemaster prices and fixed prospective payments (if applicable) are allowed to increase over the previous year.³¹ The targets account for a number of factors, including community needs, service utilization and hospitals’ overall financial health.³²

Hospitals can request increases in the amount their budgets are allowed to grow. Increases may be permitted if the GMCB deems necessary, for example, if “extra money is needed to fulfill government mandates or if the expense meets other standards that the Board has set.”³³ By law, the GMCB has strong enforcement authority to keep hospitals within their budgets, including the ability to impose financial penalties and take hospitals to court.

Prior to the hospital budget review, net patient revenue grew an average of 7.3% per year (from 2005-2013). Net patient revenue growth fell to an average of 4.0% per year after the practice began.³⁴ Differences in the budgets

hospitals have requested versus those approved range from over \$160,000 to \$17 million *per year*, generating significant savings for the state’s healthcare payers, including consumers, over time.³⁵

Price Caps as a Condition of Healthcare Mergers

Healthcare organizations typically argue that mergers improve efficiency and create economies-of-scale, improving quality and reducing costs, yet little reliable evidence supports this claim.³⁶ In fact, ample evidence demonstrates that healthcare mergers increase prices and that less competition leads to lower quality.³⁷

States often place conditions on healthcare mergers in an attempt to mitigate potential anti-competitive effects.³⁸ These conditions, delivered in the form of consent decrees, may include prohibitions against raising prices above certain thresholds for a specified period of time. Evidence suggests that price caps as a condition of healthcare mergers are effective, but typically only in the near-term. Once the period of regulation is over, providers tend to increase their prices—reversing the desired effect.³⁹

Strategy in Action: Price Caps as a Condition of Healthcare Mergers

The Massachusetts’ Attorney General’s office’s Bureau of Health Care and Fair Competition negotiated a consent decree that included price caps, among other conditions, in Beth Israel Deaconess Medical Center’s 2018 merger with Lahey Health.⁴⁰ The agreement prohibits the newly formed entity from increasing prices higher than the state’s 3.1% healthcare cost growth benchmark each year for seven years. The Massachusetts Health Policy Commission estimates that the requirement will save more than \$1 billion over the regulated period.⁴¹

Impose Price Controls on Contracts between Commercial Insurers and Providers

Rhode Island’s Office of the Insurance Commissioner created affordability standards in 2010 that imposed price controls on contracts between commercial insurers and providers. The price controls included annual price inflation caps (equal to the Medicare price index plus

1 percent) for inpatient and outpatient services and transitioned traditional hospital payments to value-based payments offering a fixed fee for a given type of diagnosis and inpatient stay. A 2019 study published in *Health Affairs* found that the price controls contributed to a decline in total spending growth and out-of-pocket spending from 2007 to 2016.⁴²

Establish a Healthcare Cost Growth Benchmark

Some states have established statewide spending targets (also known as benchmarks) to constrain total hospital or healthcare spending growth.⁴³ Massachusetts was the first state to create a total healthcare spending benchmark in 2012 and a few others—Vermont, Delaware, Rhode Island, Oregon and Connecticut—have followed suit. While data from Massachusetts shows that even voluntary targets can reign in healthcare spending growth,⁴⁴ mandatory targets may be even more impactful. Complementary quality benchmarks, such as those established in Delaware, are also important to ensure that efforts to reduce spending growth do not negatively impact health outcomes.

Note: Monitoring growth in *spending*, as opposed to growth in *prices*, allows states to assess trends in utilization over time. This is important because providers can maintain or reduce their prices for particular services, but increase the number of services provided, to generate more revenue. The provision of unnecessary services contributes to wasteful spending on behalf of patients, insurers and employers.⁴⁵

Conclusion

Researchers, policymakers and consumer advocates have long been aware that healthcare prices are not commensurate with the quality of care and outcomes we receive. High and rising prices strain state and federal budgets, crowding out other important investments, and financially burden consumers through increased health insurance premiums, cost-sharing, taxes and wages diverted to fund employer-sponsored insurance. Moreover, a significant portion of consumers report delaying or forgoing needed care due to cost, undermining the fundamental mission of a system intended to support health.

As competition ceases to effectively deter excess prices, states must increase their reliance on price controls to rein in high and rising healthcare costs, while keeping a close eye on healthcare utilization and quality. This brief highlights promising strategies from across the country to advance knowledge sharing between states.

Notes

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