Hospital care costs are out of control. Price caps can help

By Roslyn Murray and Andrew Ryan April 4, 2024

Here's just the tip of the iceberg: $722.50 for a nurse to push a drug into an IV.

$21,500 for ten stitches.

The prices charged by hospitals are exorbitant and rising. Private health insurance premiums paid by working age adults are rising rapidly. Many Americans skip necessary medical care, while those who do get treated can end up bankrupt. With U.S. health care spending reaching $4.5 trillion in 2022, finding ways to cut costs has become increasingly urgent.

An experiment in Oregon shows that states can cap hospital prices without disrupting access to care. Price caps are the maximum price that goods or services can be sold at, backed by the force of law.

In October 2019, Oregon put in place an upper limit on what it pays hospitals for services provided to the 300,000 members of its state employee plan, such as state educators and public employees. The cap is two times the Medicare rates for hospital payments, so the actual maximum dollar amount varies depending on the service. The state checks payment rates and, if hospitals are paid more than double what Medicare pays, the difference is returned to the state.

As we and several colleagues reported this month in the journal Health Affairs, this program was spectacularly successful. In just two years, the state saved $107.5 million — 4% of the state employee plan's total spending. Savings were more pronounced for outpatient services, where prices were particularly high. None of the Oregon hospitals subject to the rule stopped providing coverage to state employees, even though they could have. Nor did these hospitals appear to increase prices for other privately insured populations not covered by the cap.

In related work, which is yet to be published, we found no negative effects on hospital operations, patient access, and patient experiences.

This is one of the first experiments with a legislative price cap for people with private insurance. With national reform to address the high prices for the commercially insured

unlikely, Oregon offers a successful blueprint for other states to immediately rein in prices.

Health care consolidation has resulted in hospitals with near monopolistic power. Many are the only game in town in their communities. Hospitals also have a dominant position in negotiations with insurers because the companies that purchase insurance insist on maintaining big hospitals in their network to keep their insured workers happy.

The typical market forces that keep prices in check are missing in hospital markets. At sporting events, a venue can sell a bottle of soda for upwards of $6 because fans don't have other options. Hospitals are doing something similar, except in their case it's for essential health care and prices can be in the thousands or tens of thousands of dollars.

It is essential to better align the price of receiving care with the costs of providing it — and keep hospitals from skimming excess profits off the top. Price caps offer one of the best ways to do so.

The price cap in Oregon was set at an amount low enough to generate savings but high enough that it didn't lead hospitals to opt out or restrict access — proving how important it is to strike this Goldilocks balance when setting a cap. More research is needed to understand how price caps affect access and quality of care. But it appears likely that the cap simply cut into excess profits that hospitals would not have been able to secure under more competitive conditions, without affecting care.

Hospitals have claimed that price caps would hamper the services they offer. When Indiana lawmakers were considering price caps, hospital opposition led them to increase the cap and remove penalties for exceeding it — rendering the provision toothless. In North Carolina, hospital opposition to lowering prices for state employee plans led state treasurer Dale Folwell to describe the industryas a cartel. Oregon's cap nearly didn't pass due to strong opposition from hospital lobbyists.

But Oregon's successful test run validates price caps as a model for reducing costs without disrupting access to care. The experiment also holds lessons that can help other states implement price caps more effectively.

Montana previously tried to negotiate with hospitals to set an upper limit on what they would pay, but without the backing of legislation, the program was soon abandoned. Oregon's use of legislation to establish a firm price cap helps explain why it succeeded.

More states should follow Oregon's lead. While it's tougher to negotiate without an explicit law, all public employee health care plans can still try to insist on price caps

relative to Medicare. Price caps are easy to implement, and they still allow for market negotiations to occur. Eventually, price caps could be expanded across the board for all patients. Caps can help ensure that quality and cost of care are what drive prices — not profiteering that hospitals engage in because there's no competition to stop them.

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