

Capping Provider Prices and Price Growth in the US Commercial Health Sector

5.7% of Commercial
Health Care Spending
(1.8% of Total Health
Spending)

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Issue Summary: The US commercial health insurance sector, where tens of millions of individuals under the age of 65 receive health insurance coverage, uses market-based rather than regulated prices for providers. However, over the last three decades, health care provider markets have become increasingly consolidated and, as a result, there has been a steady increase in prices for care in the commercial sector. US provider prices are high relative to provider prices in other countries and are growing faster than prices in many other US industries. Growth in provider prices has been a primary driver of the growth in commercial health insurance premiums. Ultimately, premium increases are borne by the American public. As a result, the US requires multifaceted regulatory action to address high and rapidly rising prices for care.

Policy Recommendation: We propose a three-pronged approach to regulate provider prices in the US. First, the US should introduce “backstop” price caps, which preclude prices above 500% of the 20th percentile of local prices, at the local market level. Second, the US should introduce price growth regulation that limits provider price growth and allows higher (lower) growth caps for relatively cheaper (more expensive) providers. Third, these efforts should be supported with state and federal regulation and, if necessary, legislation to provide the data and resources to support enforcement.

Potential Savings: If the “backstop” price cap alone were introduced for inpatient hospital prices, we estimate it would reduce commercial inpatient spending by 8.7%. Capping commercial outpatient prices has a somewhat higher percentage impact and capping professional services a bit lower percentage impact. Capping both inpatient and outpatient commercial hospital prices would save approximately \$38 billion, reducing commercial health care spending by about 3.2% and total health care spending by about 1.0%. Capping professional service prices would save about \$30 billion, which translates to 2.5% of commercial and 0.8% of total health care spending.¹ Moreover, the price growth cap would limit year-on-year increases in health spending and thus result in larger savings over time.

Related Literature and Evidence:

Chernew, Michael, Leemore Dafny, and Maximilian Pany. 2020. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market." Brookings Institution. Accessed Dec 8, 2020.

https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf.

Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019b. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *Quarterly Journal of Economics*, 134 (1): 51–107.

Gaynor, Martin, Kate Ho, Robert Town. 2015. "The Industrial Organization of Health-Care Markets." *Journal of Economic Literature*, 53 (2): 235–284.

Background

From 2008 to 2018, health insurance premiums grew approximately 4% per year as median household incomes stayed flat (Collins et al. 2019; U.S. Census Bureau 2020). By 2020, health insurance premiums for a family of four in the US were \$21,342 (Kaiser Family Foundation 2020). Provider price growth is one of the largest drivers of health spending and premium growth in the US. From 2007 to 2014, for example, hospital prices for inpatient care grew 42% (Cooper et al. 2019). During this same period, the US Consumer Price Index (CPI) increased by 14% (Bureau of Labor Statistics 2020).

Approximately 55% of individuals in the US have commercial insurance (Berchick et al. 2019). Whereas provider prices are set in the Medicare and Medicaid programs (as they are in most developed countries), provider prices in the US commercial health sector are market-based and often determined via bilateral negotiations between providers and insurers. Over the last 30 years, provider markets have become increasingly consolidated (Fulton 2017), strengthening providers' bargaining leverage. Robust academic literature shows that provider prices are higher in more concentrated markets and that provider mergers can raise prices significantly (Gaynor et al. 2015; Cooper et al. 2019).

In a well-functioning market, competition drives prices to efficient levels. However, in the health care sector, there are many deviations from competitive conditions that thwart market forces. First, health insurance coverage limits individuals' exposure to the cost of services they consume. Second, the quality of providers is difficult to measure, and consumers may be unable to differentiate between high-quality and low-quality providers. Third, the majority of hospital and specialist physician markets are highly concentrated (Fulton 2017). Many provider organizations possess substantial market power, which enables them to demand high prices because of this market power as opposed to high quality.

The US should pursue multiple initiatives to increase competition among health care providers, including vigorous antitrust enforcement and the introduction of insurance plans that help and incentivize patients to seek out efficient providers. However, pro-competition policy alone is insufficient to address the

rising cost of health care in the US. At this juncture, because of idiosyncrasies in health care markets in general and the high degree of concentration in provider markets in particular, there is a strong case for regulatory intervention in provider markets.

We believe some provider price variation is warranted. High-quality providers, for example, should be permitted to charge higher prices. As a result, rather than setting price levels, we are proposing price caps. Caps eliminate the top tail of provider prices, which likely reflect inefficiencies in competition in health care markets. This proposal sets out a framework for designing “backstop” price caps and for containing price growth over time.

Policy Recommendation

The policy proposal includes three components: (1) local market- and service-specific price caps that regulate maximum prices providers can negotiate, (2) service-, insurer-, and provider-specific price growth caps that limit the year-on-year growth in provider prices, and (3) oversight power for state and federal authorities. Collectively, these components are designed to address the market failures in the commercial health sector that have led to extremely high prices for some health care services. These regulations are designed to be introduced into the current health policy landscape and fit alongside other pro-competitive reforms.

Rate Caps on the Top of the In-Network and Out-of-Network Provider Price Distribution

In each geographic region (e.g., commuting zones), prices would be capped by service at 500% of the current 20th percentile of commercial in-network prices (or the 75th percentile of such service-market price percentiles nationally, if that is lower). This cap would apply to in-network and out-of-network services, and providers would be prohibited from being paid rates over this cap. Under this policy, prices are capped based on the existing negotiated rates, rather than set as a percentage of Medicare reimbursements. As a result, this proposal still allows prices to vary within and across regions.

Based on data from the Health Care Cost Institute, physician office visits at the median 20th percentile commercial price approximate Medicare reimbursements. The median 20th percentile of inpatient payments is approximately 133% of Medicare reimbursements (Chernew et al. 2020). Given the market-service distribution of prices, the price caps we propose would tend to bind around five times of Medicare. For context, across inpatient services, this price cap would impact approximately 4.5% of cases and 84.3% of providers (Chernew et al. 2020).

Annual Price Growth Caps

In addition to capping price levels, we would introduce a limit on annual price growth. For example, growth could be limited to the CPI or a moving average of annual GDP growth, plus one or two percentage points. The price growth caps would apply by insurer-provider-service combinations and would be lower for provider-service combinations with relatively high prices (and conversely, higher for provider-service combinations with relatively low prices). This flexibility could allow prices to converge over time if supported by market demand.

Investment in Federal and/or State Agencies to Administer Regulations

Introducing, enforcing, and updating the price caps will require technical support. Indeed, there is potential for providers to circumvent the price caps, for example by paying providers using different payment systems (e.g., per diems) or by making payments outside of the claims systems (e.g., quality bonuses or shared savings payments). Construction and enforcement of the caps require a mechanism to account for these activities. As a result, we also recommend that the agencies administering these regulations adjust for any payments outside of the claims system. Moreover, state and federal officials should oversee the regulation and take action if needed. The federal government should set the policies, drive the setting and adjusting of the price caps, require submission of the necessary data, and periodically review the regulatory program. States should be responsible for administering the system locally. Crucially, at present, much of the expertise to manage and run these sorts of regulatory programs day-to-day already exists at the state level.

Potential Savings

If the “backstop” price cap alone were introduced for inpatient hospital prices, we estimate it would reduce commercial inpatient spending by 8.7%. Capping commercial outpatient prices has a somewhat higher percentage impact and capping professional services a bit lower percentage impact. Capping both inpatient and outpatient commercial hospital prices would save approximately \$38 billion, reducing commercial health care spending by about 3.2% and total health care spending by about 1.0%. Capping professional service prices would save about \$30 billion, which translates to 2.5% of commercial and 0.8% of total health care spending. Moreover, the price growth cap would limit year-on-year increases in health spending and thus result in larger savings over time.

Addendum

This addendum was prepared by the Health Care Affordability Lab at Yale.

Since this brief's publication, provider prices have remained high and continue to rise. Private insurers' hospital prices rose 30% from April 2019 to April 2026, 47% faster than the 21% increase in Medicare rates over the same period ([KFF 2026](#)). Hospitals drove 40% of the growth in national health spending between 2022 and 2024, and hospital prices grew 3.4% in 2024, their fastest rate since 2007 ([KFF 2026](#)). [Cooper et al. \(2022\)](#) found that patients have lower mortality when receiving care at higher-priced hospitals, but also find that this price/quality relationship is only present in hospital markets that are competitive.

After this brief was published, some states have advanced provider price caps. For example, Indiana's [2025 law](#) requires nonprofit hospital systems with at least \$2 billion in annual patient revenue to lower their prices to the state average by the end of June 2029 or lose their tax-exempt status. These hospital systems must also offer direct contracts to employers for their procedures, priced at or below 260% of what Medicare would pay. [Vermont](#) also passed legislation in 2025 that will direct its Green Mountain Care Board to implement Medicare-benchmarked prices for hospitals across the commercial market in hospital fiscal year 2027.

Other states have capped payments within their own employee insurance plans to a percentage of Medicare rates, including Washington, Oregon, and New Mexico ([Georgetown CHIR 2025](#)). Oregon's policy has generated an estimated \$50 million in savings without harming hospital operations or access to care ([Murray et al. 2025](#)). [Montana](#)'s state employee plan pioneered this approach, using reference-based pricing beginning in 2016 to cap facility prices as a multiple of Medicare. The program saved Montana \$47.8 million from fiscal years 2017 to 2019, though the state has since restructured its administration and rate targets.

Some states have capped hospital price growth instead. [Rhode Island](#)'s Affordability Standards, which began in 2010, require fully insured health plans to obtain the Health Insurance Commissioner's approval before contracting for average hospital reimbursement rate increases above Consumer Price Index (CPI) plus 1%—using premium rate review authority to reach the provider prices driving premiums. One study finds the Affordability Standards were associated with an estimated [5.8% net decrease](#) in quarterly total health spending per commercially insured enrollee in Rhode Island, compared to commercially insured enrollees in other states. [Delaware](#) adopted a similar policy in 2021, capping annual commercial price growth at the greater of 2% or the CPI plus 1%.

Footnotes

- 1 In 2019, total health care spending and total commercial health care spending (i.e., spending on the privately insured) were approximately \$3.8 trillion and \$1.2 trillion, respectively (CMS 2020).

References

Berchick, Edward, Jessica Barnett, and Rachel Upton. 2019. "Health Insurance Coverage in the United States: 2018." United States Census Bureau. Accessed Dec 8, 2020. <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>.

Bureau of Labor Statistics. 2020. "Consumer Price Index U.S. City Average All Urban Consumers (CPI-U): All Items." Bureau of Labor Statistics. Accessed Dec 8, 2020. https://www.bls.gov/regions/midwest/data/consumerpriceindexhistorical_us_table.pdf.

Collins, Sara, David Radley, and Jesse Baumgartner. 2019. "Trends in Employer Health Care Coverage 2008–2018: Higher Costs for Workers and Their Families." The Commonwealth Fund. Accessed Dec 8, 2020. <https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018>.

Chernew, Michael, Leemore Dafny, and Maximilian Pany. 2020. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market." Brookings Institution. Accessed Dec 8, 2020. https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf.

Cooper, Zack, Stuart V. Craig, Martin Gaynor, Nir J. Harish, Harlan M. Krumholz, and John Van Reenen. 2019a. "Hospital Prices Grew Substantially Faster Than Physician Prices for Hospital-Based Care in 2007–14." *Health Affairs*, 38 (2): 184–189.

Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019b. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *Quarterly Journal of Economics*, 134 (1): 51–107.

Centers for Medicare and Medicaid Services. 2020. "2019 National Health Expenditure Fact Sheet." Centers for Medicare and Medicaid Services. Accessed Dec 30, 2020. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>.

Fulton, Brent. 2017. "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses." *Health Affairs* 36 (9): 1530–1538.

Gaynor, Martin, Kate Ho, Robert Town. 2015. "The Industrial Organization of Health-Care Markets." *Journal of Economic Literature*, 53 (2): 235–284.

Kaiser Family Foundation. 2020. "Employer Health Benefits 2020 Summary of Findings." Kaiser Family Foundation. Accessed Dec 8, 2020. <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2020.pdf>.

U.S. Census Bureau, "Real Median Household Income in the United States [MEHOINUSA672N]." retrieved from FRED, Federal Reserve Bank of St. Louis. Accessed Dec 7, 2020. <https://fred.stlouisfed.org/series/MEHOINUSA672N>.