Recent efforts to control spending, including accountable care organizations, value-based payment, and high-deductible health plans, have emphasized optimizing patterns of health service use. The next wave of cost-containment efforts is beginning to focus attention on prices. Under the American Rescue Plan Act, the Medicare Part D program will, for the first time, regulate prices of 10 costly pharmaceuticals. On the health care services side, a recent bipartisan Health Affairs Council on Spending and Value calls for regulation of commercial hospital rates in markets with insufficient competition.

It is well-known that high prices are the main reason that per person health care spending in the US is well above levels in other countries.¹² Policymakers, however, have been understandably reluctant to address US health care prices directly. In competitive markets, regulating prices below market equilibrium levels is usually considered a bad idea because consumers demand more goods and services when prices fall, but producers become less willing to supply those goods and services, leading to shortages. If this is the case, price regulation lowers health care spending but at the expense of comprising access.

That logic does not apply, however, when suppliers (eg, manufacturers of medications under patent, hospitals that face little local competition) are able to sustain prices that are substantially higher than their costs of producing additional units. In such situations, regulating prices can expand markets. Reducing prices lowers the out-of-pocket liabilities and premiums for patients, leading them to seek more services, and as long as the newly regulated prices do not fall below the cost of covering this increased use, drug manufacturers and hospitals will supply what is needed to fill this increased demand. Standard economic theory explains that regulating prices in markets where suppliers have monopoly power in the short run, especially market power that is entrenched where competitors cannot enter, is efficient and beneficial.³

But problems with regulating prices in less competitive markets might arise in the longer run by reducing incentives to innovate. For example, lowering prices decreases the profits of suppliers, which means pharmaceutical production will be less lucrative, fewer investor dollars will flow to the biotech industry, and the pace of drug development will slow. It means that hospital margins will decline and that investments intended to improve quality, especially through large fixed-cost investments (such as magnetic resonance imaging machines) whose cost may not be recouped under lower prices, might decrease. These dynamic responses that emerge over the long run have long generated resistance to price regulation, even in noncompetitive markets where there are clear short-run gains from regulation.

The trade-off between short-run gains and the long-run dynamic costs of price regulation cannot be resolved conclusively through economic theory and logic. The gains from price regulation come from the value of the goods and services that patients access when prices decrease. The costs come from the value of the drugs and the quality of the investments that manufacturers and hospitals forego when profits decline. Whether the gains exceed the costs is an empirical question that depends on the specific context.

In some settings, research suggests that the gains to people from lower prices today are substantial and are much greater than one might expect. Under the standard model, when prices increase, the first consumers to stop using a good or service are those who gain the least from it. That behavior pattern suppresses the short-run costs associated with higher prices in noncompetitive markets.
markets. However, a growing literature shows that patients are poor judges of the value of health services. In the 1970s, the RAND Health Insurance Experiment showed that people faced with higher cost sharing reduced their use of health services, and they were equally as likely to cut back on useful services (such as hypertension screenings) as they were on less useful services (such as treatment of upper respiratory infections). The study results hold up today even though health care information is readily available on the internet.

A recent study found that Medicare Part D beneficiaries who faced higher prices of prescription drugs when they reached the coverage donut hole cut back on all their medications, including those that were lifesaving. In fact, those who were most likely to benefit from medications were more likely to cut back. When faced with greater cost sharing, many people simply stopped taking all their drugs. As a result, spending just $100 less per month increased monthly mortality by 14% even though the medication cutbacks lasted only a few weeks. Cost sharing for prescription drugs was intended to reduce wasteful spending, but may have introduced its own waste. And even though higher out-of-pocket costs have troubling direct effects on health care use, other research shows that insurer-paid pharmaceutical and hospital prices drive higher health insurance premiums, which discourage people from buying coverage altogether, shift private plans toward higher cost sharing, and lead people to choose lower-quality health insurance plans.

At the same time, research suggests that the dynamic losses from price regulation come closer to (or even fall below) those in the textbook model in less competitive markets. Although patients typically do not know which drugs will provide the greatest benefits, drug manufacturers are likely to be good judges of profit opportunities. If manufacturers expect lower profits, they may leave promising treatments on the shelf and delay the costly process of conducting a trial, and because overall profits depend on the size of the market for a drug, the drugs that do not enter production are typically those with many competitors, modest benefits, or few expected patients.

Longer-term losses are likely to be even smaller than the textbook case on the hospital side. That is because the underlying premise that higher prices generate investments in higher quality may not even be true, especially in noncompetitive markets. Research on hospital productivity in Medicare finds that hospitals often misallocate their resources, and the hospitals that spend less may have outcomes that are as good as the hospitals that spend more. In the commercial market, hospitals paid higher prices do have better mortality outcomes, but that is only true in less concentrated markets. In markets with little competition, hospital prices are high but quality is lower than in competitive markets.

Skeptics are correct to be cautious about price regulation because in competitive markets it is usually a bad idea, and even in noncompetitive markets, it can cause problems. But proceeding with caution does not mean giving up on price regulation entirely. Currently, in brand-name pharmaceutical markets and noncompetitive hospital markets, the short-term losses from high prices are substantial and they clearly outweigh the likely gains from future investments and innovation. Recent increases in insurance coverage through the Affordable Care Act and the Inflation Reduction Act, and gains in the breadth of coverage available to seniors through Medicare Part D, are imperiled by high and increasing prices. It is time to look at the evidence, not the textbook, and regulate prices in health care markets where competition cannot do the job.
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