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A Decisionmaker's Guide to Competing Health Evidence

The Center for American Progress (CAP) Health Cost Proposal: Prior Authorization, Hospital Price Caps, and the Consolidation Argument

A new proposal from the Center for American Progress would replace most prior authorizationwith independent clinical review, cap some hospital pricesand their growth, and limit insurer profits. Here's what the evidence supports, where it's thinner, and what to watch closely.

AT A GLANCE

The Proposal

CAP's "A Patients' Bill of Rights to Lower Health Care Costs" — federal reforms targeting hospital prices and price growth, prior authorization, and insurer profits.

Who's Saying What?

- CAP and consumer groups say the proposal targets the two biggest pain points: prices and prior authorization.
- Hospital groups say price caps could undermine financial stability and force service cuts.
- Health economists largely agree with the diagnosis of market power but some may question whether the initial price cap reaches enough of the market.
- Critics on the left say the package is directionally right but not aggressive enough.
- Critics on the right argue the proposal relies too heavily on federal price-setting, which they say distorts markets and discourages innovation.
- Insurers say they support prior authorization reform in principle and have pledged voluntary changes, but argue that utilization management serves a necessary cost-control function and that eliminating it without a tested replacement risks higher spending.

1. Why This Matters Right Now

If you've gotten a medical bill that made no sense, waited weeks for your insurer to approve a treatment your doctor already ordered, or watched your deductible climb while your paycheck didn't, you're not alone. For most Americans with insurance, the problem isn't getting coverage; it's affording the coverage they have.

Employer premiums have risen steadily over the past five years. Deductibles have outpaced wages. And **a KFF poll published in February 2026** found that 34 percent of insured adults named prior authorization, the process of getting your insurer's permission before receiving care, as their single biggest burden.

Into this frustration steps the Center for American Progress with **"A Patients' Bill of Rights to Lower Health Care Costs,"** released April 7. The proposal has three main parts: replace most prior authorization with independent clinical review, (while retaining pre-review for high-cost, widely overused services), cap hospital prices in concentrated markets at three times Medicare rateswith an annual growth limit of inflation plus one percent, and impose new limits on insurer profits. At the state level, **lawmakers in Delaware, Vermont, and Maine** are already debating similar hospital price-cap bills. CAP's proposal turns those state-level pressures into a federal package.

The stakes cut in several directions. If CAP is right, these reforms could reduce what families pay for care. If hospital critics are right, capping prices could strain facilities, especially in rural areas. And if critics on the left are right, the initial caps may not change prices enough.

The question isn't whether affordability is a real problem. It's whether this proposal addresses the problem.

* Updated April 28, 2026: This edition has been updated to reflect additional detail on the CAP proposal's growth cap provision and composite cap structure, to correct the characterization of prior authorization reform, and to tighten the description of state-level price cap activity. The overall assessment is unchanged.

2. Why Do Smart People Disagree?

Almost everyone agrees health care costs too much. The disagreement focuses on what's driving those costs and who should bear the cost of fixing them.

On hospital prices, CAP cites evidence that **some hospitals charge three or four times Medicare rates**, and calls that a market failure. Hospitals argue Medicare doesn't cover their costs and commercial prices fill the gap. Both claims draw on real evidence, but they're answering different questions: what patients should pay versus what hospitals say they need.

On prior authorization, almost no one defends the current system. Physicians report delays, and patients drop treatment. But once the conversation shifts to what should replace it, the evidence grows thinner. The harm is well documented; the replacement model is not.

Underneath both debates sits consolidation. CAP frames concentrated markets as the root cause of high prices. Many economists agree. But there's a real debate about remedy: price caps address the symptom, while antitrust enforcement addresses the structure. CAP explicitly endorses antitrust alongside its cap proposals, but acknowledges that structural reform is longer-term and probably not comprehensive on its own. The near-term package is mostly about managing consolidation's consequences, not reversing them.

THE QUESTIONS BEHIND THE DEBATE

The Question	What It's Really Asking	Who Tends to Ask It
Will this lower what families actually pay?	Whether the prices people see on their bills, premiums, and deductibles will actually go down.	Consumer advocates, employer groups, affordability-focused lawmakers.
Can hospitals survive if prices are capped?	Whether hospitals can keep operating, staffing, and offering essential services if their commercial revenue drops.	Hospital associations, rural health advocates, safety-net providers.
Is the problem prices, or the market power behind them?	Whether high prices are the core issue, or whether they're a symptom of too few competitors in too many markets.	Health economists, antitrust scholars, federal and state regulators.

3. What Does the Evidence Show?

What we know:

Prior authorization causes measurable harm and wastes enormous resources. The case for reform is strong.

What we don't know:

Whether CAP's proposed replacement, including the criteria for retaining pre-review on some services, can manage utilization without recreating the delays it's designed to eliminate.

On Prior Authorization

The evidence that prior authorization causes harm is strong. **The AMA's 2024 physician survey** found that 93 percent of physicians said it delays necessary care. Twenty-nine percent reported a serious adverse event, including hospitalization or death. **A 2026 systematic review** in the American Journal of Medicine found associations with disease worsening, preventable hospitalization, and worse outcomes across multiple clinical areas. Physicians spend roughly 13 hours per week on prior authorization paperwork. **The AHA reports** that hospitals spent $43 billion in 2025 just to pursue payment from insurers.

The harder question is what replaces it. CAP proposes replacing most prior authorization with independent clinical review and decision support, while retaining 48-hour pre-review for high-cost and widely overused services. That distinction matters, but the proposal doesn't specify how those services would be identified, who would make the determination, or what evidence standard would apply. If insurers decide which services keep pre-review, the current system could survive under a new name. If the government decides, it needs a regulatory apparatus that doesn't yet exist. That could work, but it hasn't been tested at scale. **A March 2026 study in JAMA Health Forum** found that when 19 states banned prior authorization for buprenorphine, a treatment for substance use disorder, it didn't improve the number of people who stayed on treatment. The problem wasn't just the paperwork barrier. Patients also needed available providers, access to counseling, and sustained support. Removing prior authorization alone wasn't enough.

What we know:

Hospital prices are high, vary widely, and are driven by market power. Oregon's cap generated real savings. No hospitals refused to participate.

What we don't know:

How hospitals would respond to a broader federal cap. Whether the combination of a 300 percent price ceiling and a growth cap produces meaningful savings over time. Whether savings would reach patients or be absorbed by insurers.

On Hospital Price Caps

Commercial insurers pay hospitals far more than Medicare for the same services. **CBO found** that commercial prices average about 223 percent of Medicare prices. **RAND's data** puts it closer to 254 percent. **A 2024 study of 1.5 billion claims** found 246 percent, with enormous variation by market.(Note that the RAND and CBO data come from 2021-2022; hospital prices have continued to rise since then, so current average may be somewhat higher.) **CBO's review** found that the main driver of that variation is the ability of large hospital systems to charge high prices because patients and insurers don't have enough alternatives, not the underlying cost of delivering care.

Oregon's experience is the best real-world test. In 2019, the state capped prices for its employee health plan at 200 percent of Medicare. Result: $107.5 million in savings over 27 months. Out-of-pocket spending fell 9.5 percent. No hospitals left the network.It's worth noting that Oregon's cap applied to a single state plan, a small share of any hospital's total revenue. A federal cap covering all commercial payers would affect far more revenue, which is a reasonable argument for setting a broader cap higher than Oregon's.

CAP sets its initial price cap at 300 percent of Medicare, while the average is around 250 percent. That means the price cap alone would only lower prices at the most expensive hospitals, the ones well above the national average. (But the proposal also caps annual price growth at inflation plus one percent for above-median hospitals. Over time, the growth cap may be the more consequential provision, gradually tightening prices across a wider range of hospitals. HYPERLINK "https://www.hfma.org/fast-finance/hospital-price-caps-states-medicare-rates/"States that have moved forward on their own are generally setting price caps at or near 250 percent.

How hospitals would respond to a broader federal cap. Whether a cap set at 300 percent leaves too many hospitals untouched to produce broad savings. Whether savings would reach patients or be absorbed by insurers.

On Consolidation

The evidence that hospital consolidation raises prices is among the strongest findings in health services research:

- **RAND** found strong evidence linking horizontal hospital consolidation to higher prices.
- **Studies reviewed by Penn's Leonard Davis Institute** found mergers increase prices six to 18 percent.
- **A 2024 study** found the FTC challenged only about one percent of hospital mergers over two decades. The unchallenged ones that were predictably anticompetitive led to price increases of five percent or more.
- **The GAO found** that at least 47 percent of physicians were affiliated with hospital systems by 2024, up from less than 30 percent in 2012.
- Quality often doesn't improve after consolidation. **KFF describes the evidence as unclear**, with most studies finding no improvement or worse outcomes. CAP's proposal names this problem , but focuses its near-term policy tools on the prices that result from consolidation rather than the market structure that produces them. That's a pragmatic choice: antitrust alone is unlikely to reverse decades of consolidation quickly enough to deliver near-term affordability relief.

4. Risks and Unknowns

The initial price cap may not reach enough of the market, but the growth cap could change the math over time.

If average commercial prices already sit near 250 percent, a 300 percent cap mostly affects outliers in concentrated markets. But the growth cap of inflation plus one percent for above-median hospitals would gradually tighten prices for a wider range of hospitals. The question is how quickly the growth cap bites and whether hospitals can adapt without cutting services. States that have moved forward on their own are generally setting initial caps at or near 250 percent.

Savings may not reach patients.

CAP directs insurers to pass savings through as lower deductibles. But the ACA's medical loss ratio was supposed to do something similar, and CAP's own proposal acknowledges it hasn't worked well. The proposed per-enrollee profit cap benchmarked to FEHB is a design improvement, but it's untested.

Some hospitals may cut services , though the composite cap provides flexibility.

Not every hospital charging high commercial prices is gouging. Some cross-subsidize money-losing services such as behavioral health and obstetrics, which the AHA says account for 56 percent of hospital costs when reimbursement falls short. CAP's cap is a composite across all services, not a per-service cap, which means hospitals could still charge more for profitable lines and less for others as long as the blended rate stays below the threshold. That reduces but doesn't eliminate the cross-subsidization concern, particularly for rural and safety-net hospitals operating on thin margins..

Replacing prior authorization without a tested model could backfire.

CAP's proposal retains pre-review for some high-cost services but replaces prior authorization for the rest. Whether that balance works depends on questions the proposal leaves open: which services keep review, who decides, and on what evidence. If the criteria aren't clearly defined, the retained reviews could quietly expand back toward the status quo, or the eliminated ones could produce a short-term spending increase that opponents use to discredit the reform. **The buprenorphine study** is a reminder: removing a barrier doesn't automatically fix the problem it's supposed to address.

Price caps without antitrust reform could entrench the problem of consolidation. CBO's analysis suggests competition-promoting policies may yield smaller short-run savings but larger long-run ones. CAP endorses antitrust enforcement alongside its cap proposals, which is the right instinct. But if caps become a substitute for structural reform rather than a bridge to it, the market may stay just as concentrated.

5. How to Read the Evidence Yourself

When you encounter a study or claim about this debate, here are three questions worth asking:

- **Who's being compared to what?** Most studies express hospital prices as a percentage of Medicare rates. But Medicare rates are set by the government, not the market. A hospital charging "300 percent of Medicare" sounds extreme, but if Medicare underpays, the ratio overstates the markup. When you see these numbers, ask whether the study accounts for differences in hospital efficiency. **MedPAC's data** show that efficient hospitals can post positive Medicare margins, suggesting the "shortfall" isn't uniform.

1. **Does the study assume everyone holds still?** Savings estimates often assume hospitals absorb the price cut and insurers pass savings to consumers. In reality, hospitals might shift services, consolidate further, or cut capacity. Oregon's real-world data is more useful than models precisely because it captures how people actually responded.

2. **Does the evidence match the scope of the policy?** Oregon's cap covered one state employee plan. The buprenorphine study examined one medication. Neither tells you exactly what would happen under a broad federal cap or a nationwide change to prior authorization. When a study is cited as evidence for a sweeping policy, check whether the study population matches the policy's reach.

Common ways the evidence gets overstated

- **Claiming a 300 percent cap is sweeping** when the average price is already around 250 percent. It mostly affects outliers. The reverse is also common: claiming it would devastate hospitals, even though most are already below the threshold.

- **Treating cost-shifting as a settled fact.** Hospitals argue they must charge private payers more because Medicare underpays. It's intuitively appealing, but CBO found little evidence that payer mix explains most price variation, and **MedPAC** has repeatedly highlighted differences in hospital efficiency.

A note on sources

CBO is the most methodologically neutral source in this debate. RAND's hospital pricing data is influential but partly funded by employers with a stake in lower prices. AHA and AMA reports are useful but advocacy-oriented. KFF polling is strong on public attitudes. When in doubt, weight CBO, peer-reviewed research, and real-world state data (like Oregon) most heavily.

6. The Bottom Line

The most useful next questions for research are practical:

- What happens to utilization and spending when prior authorization is replaced at scale?
- How do hospitals respond to a combination of price caps and growth caps across a broad commercial payer mix?
- Do price caps reduce pressure for structural reform or create room for it?

Decisionmakers would be better served if those answers arrived before the next round of legislation, not after.

The CAP proposal rests on well-supported premises. Prior authorization causes widespread harm. Hospital prices in concentrated markets are high and hard to justify on quality grounds. Consolidation has strengthened market power, and enforcement hasn't kept pace. None of that is controversial.

The prescription is where it gets harder.

On prior authorization, the case for reform is strong. The case for CAP's specific replacement model is less settled, particularly the criteria for deciding which services retain pre-review.. A phased rollout with built-in evaluation would better match what we actually know.

On hospital price caps, Oregon's results are encouraging. The initial cap of 300 percent of Medicare mostly reaches the upper tail of the distribution. But the growth cap of inflation plus one percent may prove more consequential over time, gradually tightening prices for a wider set of hospitals. Whether the combination delivers broad affordability relief depends on implementation details that remain undefined.

On consolidation, the proposal names the right structural problem and endorses antitrust enforcement as part of the answer. But the near-term tools are primarily about managing consolidation's consequences. Price caps address the symptom. They don't unwind the market power that created it.

Importantly, this debate reflects a broader shift. For years, the Democratic health policy agenda focused on expanding coverage. CAP's proposal signals a pivot toward affordability for people who already have insurance. Whether it is feasible will depend on whether the details prove as strong as the diagnosis.

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