with SCD, and a reduction from 14.8% to 11.4% (3.4-percentage-point difference [95% CI, 1.0-5.9]; P = .005) among patients with cancer with bone metastasis (**Figure 1**). Comprehensive mandates were associated with a reduction in mean MMEs dispensed from 688.3 to 366.5 (difference, 321.8 [95% CI, 51.5-592.2]; P = .003) to patients with SCD (**Figure 2**) but no change in MMEs for patients with cancer with bone metastasis. Noncomprehensive mandates were not associated with significant changes in either outcome.

Discussion | Comprehensive PDMP mandates were associated with substantial reductions in opioids dispensed to patients with SCD or cancer with bone metastasis following ED encounters. Potential explanations include decreased prescribing due to clinician concerns about misuse or diversion, increased administrative burden, and prescriber perception of liability associated with opioid prescribing. Study limitations include lack of data on whether opioids were clinically indicated and whether prescriptions were written by ED or non-ED clinicians. Future studies should consider whether opioid prescribing policies restrict appropriate uses and limit access to treatment for patients with serious acute pain.

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1. Lanzkron S, Carroll CP, Haywood C Jr. The burden of emergency department use for sickle-cell disease: an analysis of the national emergency department sample database. *Am J Hematol*. 2010;85(10):797-799. doi:10.1002/ajh.21807

2. Mayer DK, Travers D, Wyss A, Leak A, Waller A. Why do patients with cancer visit emergency departments? results of a 2008 population study in North Carolina. *J Clin Oncol*. 2011;29(19):2683-2688. doi:10.1200/JCO.2010.34.2816

3. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv*. 2020;4(12):2656-2701. doi:10.1182/bloodadvances.2020001851

4. Wen H, Hockenberry JM, Jeng PJ, Bao Y. Prescription drug monitoring program mandates: impact on opioid prescribing and related hospital use. *Health Aff (Millwood)*. 2019;38(9):1550-1556. doi:10.1377/hlthaff.2019.00103

5. Dowell D, Haegerich T, Chou R. No shortcuts to safer opioid prescribing. *N Engl J Med*. 2019;380(24):2285-2287. doi:10.1056/NEJMp1904190

COMMENT & RESPONSE

Backstop Price Caps in Commercial Health Care Markets

To the Editor In their recent Viewpoint[1] about regulation of health care prices, the authors claimed that instituting a price backstop for commercial insurance markets would limit the ability of consolidated health systems to exploit their growing market power. Although this approach has many virtues, as described, a flat backstop would serve as a blunt instrument for restraining prices.

By cutting prices equally across the board for all services, the backstop does not account for the relative value of different services. Additionally, using Medicare rates as a baseline further entrenches the relative disparity in Medicare's reimbursement policies, favoring procedures over cognitive medicine. For example, the authors' proposal would cut the prices by equivalent amounts for arthroscopic surgery for knee osteoarthritis and for alcohol/substance use disorder screening, brief intervention, and referral to treatment (SBIRT). Currently, knee arthroscopy reimburses for $721 and costs more than $50 000 per quality-adjusted life-year (QALY) while SBIRT (>30 minutes) currently reimburses for $67.69 and costs less than $1000 per QALY.[2-4] In a value-based pricing model, to better align incentives, knee arthroscopy should be subject to a price cap while a price floor should be set for SBIRT.

A flat-price backstop would decrease margins on all services equally, even though many high-value, predominantly cognitive services with comparably low reimbursements face greater pressure to prioritize efficiency than some low-value procedural services. With a price backstop, this pressure to maximize profit margins would increase further for health

systems. One positive consequence of this strategy may be that health systems, hospitals, and clinics would cut costs and improve efficiency. However, health systems with extensive market power could pursue a different strategy: attracting patients for low-value, higher-margin procedures while cutting low-margin, high-value services, resulting in safety-net hospitals disproportionately providing important high-value services at low margins.

We suggest that a more effective solution than a flat backstop would be to integrate price controls and value-based reimbursement models. To promote value in health care, we must align economic incentives to support the delivery of high-value services: the dual aim of price controls and value promotion can therefore be achieved through thoughtful price control policies.

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1. Chernew ME, Pany MJ. Regulation of health care prices: the case for backstop price caps in commercial health care markets. *JAMA*. 2021;325(9):817-818. doi:10.1001/jama.2020.26821

2. Barbosa C, Cowell A, Bray J, Aldridge A. The cost-effectiveness of alcohol screening, brief intervention, and referral to treatment (SBIRT) in emergency and outpatient medical settings. *J Subst Abuse Treat*. 2015;53:1-8. doi:10.1016/j.jsat.2015.01.003

3. Marsh JD, Birmingham TB, Giffin JR, et al. Cost-effectiveness analysis of arthroscopic surgery compared with non-operative management for osteoarthritis of the knee. *BMJ Open*. 2016;6(1):e009949. doi:10.1136/bmjopen-2015-009949

4. Centers for Medicare & Medicaid Services. CMS-1734-F. Accessed April 13, 2021. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f

In Reply Mr Lusk and Dr McDevitt argue that backstop price caps on the highest of health care prices would be "a blunt instrument for restraining prices." Their assessment is based on 2 misperceptions of the caps we discussed in our recent Viewpoint.[1] First, the approach we outlined would not cut prices equally across the board for all services. On the contrary, backstop price caps are intended to be service specific, so that the amount trimmed depends on the amount by which the price for a specific service exceeds the cap. By design, backstop price caps would apply only to the highest prices within each service. Second, we illustrated a cap approach based on a multiple of the 20th percentile of commercial rates, which translated to about 5 times Medicare fees, but is not based on Medicare. This strategy allows market forces to contribute to the level of the caps, although the use of Medicare rates is administratively simpler.[2] We apologize if our Viewpoint was not clear on these points.

Lusk and McDevitt argue that price caps should be value based. On this point, we disagree. Ideally, prices should be driven to the cost of efficient production, not set based on a cost-effectiveness threshold. Our proposal operationalized the concept of efficient production based on the 20th percentile of existing prices, but we proposed a generous (5×) multiple to account for unobserved quality and measurement issues. For example, assuming a 5× multiple, if SBIRT were commonly offered at $68, only prices greater than $340 would be trimmed (though facility fees are more likely than professional fees to exceed the caps). The extent of the trimming would depend on how far the price was above the cap, and the appropriate multiple is a policy decision. Importantly, though, as discussed in our Viewpoint,[1] we recognize that differential quality is an important concern, and we do not advocate a QALY-based cap. Thus, $721 for knee arthroscopy, cited by Lusk and McDevitt as not cost-effective, would not be trimmed if it were in line with the prices charged by other providers of knee arthroscopy. We acknowledge that a regulatory approach to deal with services found not to be cost-effective, even if efficiently produced and priced, is indeed important, but beyond the scope of our proposal.

We agree with Lusk and McDevitt that high prices in the US health care system represent a problem that markets alone are unlikely to solve. Therefore, we believe that limited government action designed to target the most likely areas of market failure is important. We are under no illusions that this is an easy task and are specifically concerned about circumvention and enforcement. Yet, to have a health care system that provides equitable access to high-value services in a fiscally sustainable manner, the US needs to do better.

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1. Chernew ME, Pany MJ. Regulation of health care prices: the case for backstop price caps in commercial health care markets. *JAMA*. 2021;325(9):817-818. doi:10.1001/jama.2020.26821

2. Chernew ME, Dafny LS, Pany MJ. A proposal to cap provider prices and price growth in the commercial health-care market. The Hamilton Project. Published March 10, 2020. Accessed October 7, 2020. https://www.hamiltonproject.org/papers/a_proposal_to_cap_provider_prices_and_price_growth_in_the_commercial_health_care_market

Strategies to Overcome the Market Dominance of Hospitals

To the Editor In their recent Viewpoint,[1] Dr Kocher and colleagues illuminated the concerning trend of hospital-dominated markets that has contributed to unsustainable