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How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan

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Policy Points

- States grappling with high and rising health care spending can draw inspiration from the Oregon State Employee Plan's hospital payment cap program, which was found to reduce hospital prices and spending.
- Tailoring the cap to states' specific price levels and market dynamics may help enhance the efficacy of hospital payment cap initiatives across different states.

ABSTRACT

The State of Oregon passed legislation in 2017 that prohibits hospitals from charging the state employee plan more than 200% of what Medicare pays for in-network hospital facility services and 185% for out-of-network prices. The law took effect starting in October 2019 and led to reductions in hospital services that generated more than $100 million in savings for the state employee plan in the first 27 months of implementation. Oregon's experience can inform other state employee plans' efforts to control health care price and spending growth. We offer key lessons for states considering payment cap policies, which include:

- By setting the payment cap well above Medicare prices but below the state employee plan's prices, Oregon effectively curbed prices while maintaining provider participation in the network.
- Oregon's decision to exempt small, rural, critical access, and certain sole community hospitals helped protect the financial stability of vulnerable facilities and maintain hospital participation in the network.
- Oregon established a cap on out-of-network services at 185% of Medicare, which was below the in-network payment limit. All of the hospitals subject to the legislation remained in-network.
- Oregon mandated payment caps through legislation, which will make them more durable against repeal or abandonment.

INTRODUCTION

A major reason the United States spends significantly more per capita on health care compared to similar countries is its high prices for medical services.[1-6] Hospital prices, in particular, have played a pivotal role in driving US health care spending growth, with spending on hospital care representing $1.4 trillion or 30% of annual national health care expenditures.[7] Particularly noteworthy is the growing divide between commercial and Medicare payments for hospital services. Commercial prices are more than-two-and-a-half times higher than what Medicare pays, and they vary widely not only across and within markets, but also within hospitals.[8-11] This price variation indicates that commercial prices are influenced by a hospital's reputation and negotiating leverage.

States have become a key player in the pursuit of innovative purchasing strategies to control commercial price growth, driven by the pressing need to address rising health insurance premiums, out-of-pocket expenses, and stagnant wages among their residents.[12,13] Moreover, given requirements that states balance their budgets every year, rising health care costs for public employees crowd out resources that could be spent on other state priorities, including education, infrastructure, public health and safety, or economic development. State employee plans, with their sizable purchasing power and fiduciary responsibility of prudently managing state funds, are uniquely positioned to pursue procurement approaches aimed at controlling hospital prices for their members—and generating savings for the state.[14] The Oregon state employee plan's novel initiative to cap hospital payments is a noteworthy example of an innovative state purchasing strategy.

OVERVIEW OF THE OREGON STATE EMPLOYEE PLAN'S HOSPITAL PAYMENT CAP LEGISLATION AND SUMMARY OF FINDINGS

In 2017 Oregon passed legislation requiring insurers and third party administrators that contract with the state employee plan to cap payments for hospital facility services at 200% of Medicare for in-network and 185% of Medicare for out-of-network services. The intention of the payment cap is to effectively manage health care spending by preventing payments in excess of two times what Medicare pays, while allowing for market negotiations under the established limit. The state employee plan includes both the Public Employees Benefit Board ("public employees") and the Oregon Educators Benefit Board ("Oregon educators"), which together provide benefits for approximately 15% of the employer-sponsored insurance population in Oregon.[15,16] The hospital payment cap went into effect in October 2019 for the Oregon educators and January 2020 for the public employees. Only 24 of Oregon's 62 hospitals are subject to the policy. Exempt hospitals include rural or critical access hospitals, or sole community hospitals that were in a county with less than 70,000 people and received at least 40 percent of their revenue from Medicare.

As we reported in a recent *Health Affairs* article, our analysis found that the hospital payment cap led to reductions in the prices that the state employee plan paid for hospital facility services. Specifically, there was a 25% reduction in outpatient prices per procedure and a 3% reduction in inpatient prices per admission in the first two years and three months of the policy. Price reductions were smaller in the inpatient setting because low-priced hospitals initially increased their prices to the cap but were prohibited from doing so after the first year. We estimated that these price reductions resulted in $107.5 million in savings for the state in the first 27 months of the policy, amounting to 4% of plan spending. All of the targeted hospitals remained in-network and there was no evidence that hospitals increased their prices for the non-state employee commercial population to compensate for revenue losses.[17] Drawing from this assessment of Oregon's initiative, this issue brief outlines key insights for other state employee plans considering payment cap strategies to manage hospital prices and spending (see Table 1).

Lessons for Other State Employee Plans

Establishing the payment cap

When deciding how and where to set the payment cap, states must first determine what to use as a benchmark, typically relying on Medicare and commercial payments as primary approaches. Medicare payments are useful and broadly familiar for benchmarking purposes. They approximate the cost of care provision, formulas have been refined over time, some hospital commercial contracts are already paid based on Medicare, and they

adjust for important geographic, facility, and patient factors. However, Medicare payments may not accurately reflect costs for certain services, such as maternity care or pediatric services, and could pose difficulties for payers not paying based on Medicare rates.

The absence of readily available information on commercial rates poses a challenge for many states considering commercial payments as a benchmark, although states with all-payer claims databases (APCDs) may have the necessary commercial claims data. Another drawback of using commercial payments is that they incorporate the bargaining leverage of providers and insurers.[18,19] States could combine approaches and establish that the payment cap be the lesser of a percentage of Medicare or the median in-network commercial rate (favoring median commercial rates over mean to mitigate the influence of high-priced hospitals).[20] States could also consider Medicaid or TRICARE payment rates, which may better approximate the cost of maternity, newborn, or pediatric services.

Second, the level of the payment cap is crucial. A cap set too high will limit savings, while one set too low could strain hospitals financially, potentially impacting patient access and quality of care. States may opt for a higher initial cap, gradually reducing it over time. However, there is a risk that low-priced hospitals will seek significant, potentially unjustified price increases, as observed in Oregon.[17] The original legislation stated that payment "shall not exceed" the cap. But price increases in the first year prompted the state to revise the legislation to specify that payment shall be "the lesser of" the negotiated rate, billed charges, or the cap. Payments in excess are returned to the state by its third-party administrator (TPA).[21] States could consider multiple caps because relative prices, and thus potential savings, may differ between inpatient and outpatient settings, or for specific services like maternity care. However, implementing separate caps for different settings or services may add significant complexity compared to a uniform cap.

Several sources of data are available to assist states with setting the payment cap:

1. State employee health plan claims and pricing data can be used to identify average prices relative to Medicare payments to reference in establishing a benchmark.

2. States APCDs allow for comparisons of state employee plan prices (or commercial prices if unable to identify state employee claims) relative to Medicare payments or to identify in-network median commercial rates for benchmarking purposes.

3. Data from the Transparency in Coverage rule, which requires insurers and TPAs to disclose price and cost-sharing information by federal law, can be leveraged to identify relative prices or the in-network median commercial rate.[22]

4. The National Academy for State Health Policy's Hospital Cost Tool provides policymakers and researchers with insights into how hospitals' input costs relate to their prices and how to calculate a hospital's commercial "breakeven" rate relative to Medicare rates, and can inform the cap level decision.[23]

In-house economists, actuaries, accountants, or external consultants may be needed to conduct data analysis to establish the payment cap.

Key lesson(s). Oregon's decision to set the payment cap above Medicare rates but slightly below the estimated average payment for facility services relative to Medicare proved effective in controlling prices without jeopardizing provider participation. While using the median relative price would minimize the influence of outliers, this approach provides a valuable starting point for other states considering similar policies. However, successful implementation hinges on access to data to accurately assess facility prices relative to Medicare rates or the median in-network commercial rate and the data analytic capacity to model savings and market impacts of different payment levels.

Table 1. Lessons for States from the Oregon State Employee Plan's Hospital Payment Cap

	Considerations	Lessons
Establishing the payment cap	States must decide on a benchmark for setting payment caps. Medicare and commercial payments are the primary options, but Medicaid or TRICARE rates may better approximate certain service costs.	Oregon set the payment cap well above Medicare payments but slightly below the state's estimated average facility prices relative to Medicare payments, effectively curbing prices while maintaining provider participation.
	The level of the payment cap is critical, with a balance needed to avoid limiting savings or straining hospitals financially.	
	States need access to data sources, such as all-payer claims databases or transparency in coverage data, to help determine where to set the cap.	
Safeguarding small, rural hospitals	States should consider safeguarding hospitals that may struggle to absorb losses associated with payment caps through exemptions, varying caps based on hospital financial metrics, or instituting a payment floor.	Oregon's decision to exempt small, rural, critical access, and certain sole community hospitals helped protect the financial stability of vulnerable facilities and maintain hospital participation.
Including out-of-network payment caps	States should include out-of-network payment caps, established either at the same limit as in-network caps or below the in-network limit.	Oregon established an out-of-network cap at 185% of Medicare, below the in-network payment limit. All of the hospitals subject to the legislation remained in-network.
Legislation versus negotiation	States should attempt to mandate payment caps through legislation, which offers durability against repeal. Alternatively, states could leverage procurement power to pay hospitals based on Medicare, as seen in Montana.	Oregon mandated payment caps through legislation, which will make them more durable against repeal or abandonment.

Safeguarding small, rural hospitals

States should consider what, if any, safeguards to provide for hospitals that may struggle to absorb losses associated with payment caps. For instance, exemptions can provide relief for smaller or rural hospitals that may find it challenging to operate under payment caps due to their fixed patient base and limited ability to adjust operations or revenues. Instead of relying solely on exemptions, states could adopt a more nuanced approach by adjusting payment caps based on hospital-specific financial indicators such as operating margins for patient services only or days cash on hand. Alternatively, states could establish a payment floor to guarantee that hospitals can adequately cover their costs.

Key lesson(s). Oregon's choice to exempt small and rural hospitals, critical access hospitals, and some sole community hospitals appears to have been effective at safeguarding the financial stability of more vulnerable hospitals and allowing the continued participation of the targeted hospitals. As evidenced by the lack of hospital departures from insurance networks or closures, those subject to the legislation demonstrated resilience in managing the impacts of the payment cap. It remains uncertain how exempted hospitals would have been affected by the policy.

Including out-of-network payment caps

Payment caps will not be effective unless they also apply to out-of-network prices. In the absence of caps on out-of-network rates, hospitals can choose not to participate to secure a higher payment rate in lieu of state employee service volume. Thus, out-of-network hospitals would have the freedom to charge high rates to the state employee plan when their members receive care at an out-of-network facility. This dynamic could exacerbate states' concerns about health care affordability and access to care. States could set out-of-network caps at the same limit as in-network caps or go a step further and set the out-of-network cap below the in-network limit, as

Oregon did. In this case, hospitals that refuse to participate in the state employee plan's insurance networks might secure a lower rate than if they participated, along with losing significant service volume. Thus, the lower out-of-network limit encourages providers to remain in-network and at the negotiating table, shifting negotiating leverage to the state and its TPAs.

Key lesson(s). Oregon's legislation includes a cap on out-of-network services, set at 185% of Medicare, which is lower than the in-network payment limit. Hospitals that choose not to participate in the state employee plan's insurance networks might secure a lower rate than if they participated. To date, all 24 hospitals targeted by the legislation have stayed in-network, underscoring the effectiveness of this provision.

Legislation versus negotiation

Legislatively mandated payment caps offer several advantages, including clear mandates, enforcement mechanisms like penalties for non-compliance, and durability against repeal or abandonment. The Oregon state employee plan was able to secure passage of the payment cap by incorporating it into the budget bill.[24] This not only ensured the policy's passage but also underscored its ability to alleviate pressure on the state's fiscal budget. Despite the advantages of legislation, many states have struggled to pass payment cap legislation due to hospitals' influence on policymaking. If passing legislation is too big a hurdle, state employee plans could instead leverage their procurement process or purchasing power to require TPAs to negotiate contracts based on a percentage of Medicare payments. For instance, the Montana state employee plan implemented a reference-based pricing approach in 2016. Instead of imposing an upper limit on prices, the state paid hospitals a set percentage of Medicare rates for facility services. Therefore, payment also increased for some services. An audit estimated that the initiative saved the state employee plan $47.8 million over the first three years.[25] However, despite its success, the program was eventually discontinued due to political pressure, underscoring the benefits of legislation.

Key lesson(s). Oregon's decision to mandate payment caps through legislation enhances their durability against repeal or abandonment, a lesson learned from the experience in Montana.

Open questions and policy considerations

There are questions that have yet to be answered that states should consider as they contemplate payment caps. First, states should consider how payment caps will affect hospitals' financial positions, as well as state employee plan member premiums, benefits, earnings, access, and care quality. While the absence of hospital closures or network exits in Oregon suggests that hospitals did not struggle financially and patients did not experience serious access barriers under the payment cap, policymakers may want to consider modeling the impacts of various payment cap levels and exemptions on critical access or other essential or financially precarious hospitals. Moreover, legislation could authorize the state employee plan to adjust payment caps in the future to address adverse effects on access or hospital financial viability. However, this flexibility comes with the tradeoff that powerful hospitals may exert pressure on the state to weaken the payment caps and erase the savings.[26] Further, state employee plans should track price and utilization data internally or through the state's APCD to detect potential unintended effects, such as increases in prices for non-regulated services (e.g., professional fees), changes in service volumes or utilization patterns, or recruitment challenges following the implementation of payment caps.[27,28]

Second, states with successful state employee plan hospital payment caps might seek to expand caps to private employers for greater impact. If payment caps are applied to the broader market of privately insured enrollees, the state may need to consider granting a health care agency or office authority to establish and oversee the provider payment caps through regulation, or adding oversight mechanisms for the insurance department to ensure that health plans pass savings on to enrollees. However, with few state controls over self-insured employer-based plans due to ERISA, it may be difficult for the state to track or enforce whether private employers pass savings from payment caps to enrollees. States may also have limited visibility through their APCDs or health insurance rate review authority over the impact of the policy on private employer-sponsored health plan prices or contracts with third-party administrators.

CONCLUSION

The Oregon state employee plan's hospital payment cap is an innovative example of how state employee plans can use their purchasing power and fiduciary obligations to effectively control hospital prices and spending. Oregon's experience, which led to more than $100 million in savings within the first 27 months of implementation, provides valuable insights for other state employee plans that are looking for ways to control health care price and spending growth. However, other states' success will require a nuanced approach, tailored to the price levels and market dynamics of each state. By drawing on these lessons, states can harness the potential of hospital payment caps to achieve meaningful reductions in hospital prices and health care spending.

NOTES

1. Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the prices, stupid: why the United States is so different from other countries. Health Aff (Millwood). 2003;22(3):89-105

2. Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood). 2019;38(1):87-95

3. Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high income countries. JAMA. 2018;319(10):1024–1039.

4. Health Care Cost Institute. 2017 health care cost and utilization report [Internet]. Washington (DC): HCCI; 2019 Feb 11 [cited 2024 March 12]. Available from: https://healthcostinstitute.org/images/easyblog_articles/276/HCCI-2017-Health-Care-Cost-and-Utilization-Report-02.12.19.pdf

5. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? Hospital prices and health spending on the privately insured. Q J Econ. 2019;134(1):51-107.

6. Hartman M, Martin AB, Benson J, Catlin A. National health care spending in 2018: growth driven by accelerations in Medicare and private insurance spending. Health Aff (Millwood). 2019;39(1):8–17.

7. Centers for Medicare and Medicaid Services. National health-expenditures data: historical [Internet]. Baltimore (MD): CMS; 2023 Dec 13 [cited 2024 Feb 19]. Available from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

8. Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices paid to hospitals by private health plans [Internet]. Santa Monica (CA): RAND Corporation; 2024 May [cited 2024 June 27]. Available from: https://www.rand.org/pubs/research_reports/RRA1144-2.html

9. Ginsburg PB. Wide variation in hospital and physician payment rates evidence of provider market power [Internet]. Washington (DC): Center for Studying Health System Change; 2010 Nov [cited 2024 Feb 12] (Research Brief, No. 10). Available from: http://www.hschange.org/CONTENT/1162/1162.pdf

10. Kronick R, Neyaz SH. Private insurance payments to California hospitals average more than double Medicare payments [Internet]. Washington (DC): West Health Policy Center; 2019 May [cited 2024 Jan 12]. Available from: https://westhealth.org/wp-content/uploads/2023/11/West-Health-Policy-Center-Hospital-Pricing-Analysis-May-2019.pdf

11. Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. Health Aff (Millwood). 2015;34(12):2147-2150.

12. Arnold DR, Whaley CM. Who pays for health care costs? The effects of health care prices on wages [Internet]. Working Paper; 2020 June. Available from: https://www.ftc.gov/system/files/documents/public_events/1567421/whaleyarnold.pdf

13. Hayes SL, Collins SR, Radley DC. How much U.S. households with employer sponsored insurance spend on premiums and out-of-pocket costs: a state-by-state look [Internet]. The Commonwealth Fund; 2019 May 23. [cited 2023 Aug 8]. Available from: https://www.commonwealthfund.org/publications/issue-briefs/2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket

14. Corlette S, Davenport K. In an era of premium and provider price increases, state employee health plans target key cost drivers. Health Affairs Forefront. Published 2023 Nov 16 [cited 2024 Apr 24]. Available from: https://www.healthaffairs.org/content/forefront/era-premium-and-provider-price-increases-state-employee-health-plans-target-key-cost

15. Oregon SB 1067. Relating to government cost containment; and declaring an emergency [Internet]. 79th Oregon Legislative Assembly, chapter 746 (2017). Salem (OR): Oregon State Legislature; 2017 [cited 2024 Jan 12]. Available from: https://olis.oregonlegislature.gov/liz/2017R1/Measures/Overview/SB1067

16. National Academy for State Health Policy. New NASHP model legislation: limiting out-of-network provider rates to lower costs & increase network participation [Internet]. Washington (DC): NASHP; 2022 Nov 29 [cited 2024 Jan 12]. Available from: https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2023/01/Final-NASHP-Webinar-Slide-Deck-11.29.22.pdf

17. Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024;43(3):424-432.

18. Berenson RA, Murray RB. Guiding the invisible hand: practical policy steps to limit provider prices in commercial health insurance markets [Internet]. Washington (DC): Urban Institute; 2023 May [cited 2024 Jan 12]. Available from: https://www.urban.org/sites/default/files/2023-05/Guiding%20the%20Invisible%20Hand.pdf

19. Chernew ME, Dafny LS, Pany MJ. A proposal to cap provider prices and price growth in the commercial health-care market [Internet]. Washington (DC): The Hamilton Project; 2020 Mar [cited 2024 Jan 12]. Available from: https://www.brookings.edu/wp-content/uploads/2020/03/CDP_PP_WEB_FINAL.pdf

20. Butler J, Hensley-Quinn M. Q&A on NASHP's model act to limit out-of-network provider rates [Internet]. Washington (DC): NASHP; 2022 Nov 29 [cited 2024 May 8]. Available from: https://nashp.org/qa-on-nashps-model-act-to-limit-out-of-network-provider-rates/

21. Mercer. Hospital payment cap monitoring report. Paper presented at: OEBB/PEBB Joint Innovation Workgroup; 2021 Oct 19; virtual.

22. KFF. Transparency in coverage [Internet]. Washington (DC): KFF [cited 2024 May 8]. Available from: https://www.kff.org/transparency-in-coverage/

23. National Academy for State Health Policy. Hospital cost tool and resources [Internet]. Washington (DC): NASHP; 2022 Apr 5 [cited 2024 May 8]. Available from: https://nashp.org/hospital-cost-tool-and-resources/

24. Gray C. Senate clears hospital price controls for public worker health plans [Internet]. The Lund Report. 2017 [cited 2024 Apr 25]. Available from: https://www.thelundreport.org/content/senate-clears-hospital-price-controls-public-worker-health-plans

25. Patient Rights Advocate. From insolvency to surplus: how Montana rescued its state health plan through reference-based pricing [Internet]. PatientRightsAdvocate.org. [cited 2024 April 2]. Available from: https://www.patientrightsadvocate.org/montana-case-study

26. Murray R. Rate regulation revisited: managing regulatory failure and regulatory capture in health care [Internet]. Milbank Memorial Fund. 2022 Oct [cited 2024 Apr 25]. Available from: https://www.milbank.org/publications/rate-regulation-revisited-managing-regulatory-failure-and-regulatory-capture-in-health-care/

27. Office of the Health Insurance Commissioner. Next generation affordability standards: concept, rationale, and additional information [Internet]. Providence (RI): OHIC; 2021 [cited 2024 Mar 25]. Available from: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-05/OHIC%20Next%20Generation%20Affordability%20Standards%20Concept%20Paper.pdf

28. Whaley CM, Brown TT. Firm responses to targeted consumer incentives: evidence from reference pricing for surgical services. J Health Econ. 2018;61:111-133.

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