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A Menu of State Choices for Addressing Unaffordable Growth in Hospital Commercial Prices

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Policy Points

- State health care cost growth target programs do not hold hospitals accountable for rising hospital prices, which drive half of all health care spending.
- Potential state strategies to address hospital prices range from additional transparency measures to prospectively reviewing and approving hospital revenue and/or price growth.

ABSTRACT

In recent years, health care cost growth has been driven mostly by growth in average prices for health care goods and services. A number of states have established health care cost growth targets to address this issue, but these programs do not directly hold hospitals accountable for their rising prices. This brief outlines seven potential strategies to address high and rapidly rising hospital prices, accompanied by examples from states that have successfully implemented these approaches. The strategies are (1) publishing data on hospital prices and price growth; (2) tying the terms of hospital certificate of need and cost and market impact review approvals to the cost growth target value; (3) taking direct action on narrower hospital pricing policy issues like facility fees; (4) creating a complementary hospital price growth target; (5) setting a hospital price cap; (6) setting a hospital price growth cap; and (7) prospectively reviewing and approving hospital revenue and/or price growth.

INTRODUCTION

Rapidly rising prices have been the major driver of health care cost growth in the commercial health insurance market in recent years. Nationally, from 2018 to 2022, the increase in health care spending was largely driven by rising average prices for health care goods and services, which grew by 14%, while utilization grew by 4%.[1] Growth in prices for hospital inpatient services (20%) was second only to the 21% increase in prescription drug prices. Rebates — pharmaceutical manufacturers' discounts for health insurers and pharmacy benefit managers — likely offset a meaningful amount of the growth in prescription drug prices. In 2022, hospital inpatient care, hospital outpatient care, and professional services accounted for over three-quarters (76.7%) of total spending. To effectively control health care cost growth, states must address the rise in provider prices, particularly for hospital inpatient and outpatient care, which accounted for nearly 50% of total spending in 2022.

To address health care cost growth, a number of states have established programs based on a health care cost growth target or benchmark.[2] This target is a shared expectation of how much per capita total health care spending should grow annually in the state, set with input from the health care industry, employers, and consumer advocates. These programs aim to slow the rate of health care cost growth through public engagement, measurement, transparency, accountability, and complementary cost growth mitigation strategies. An inherent challenge of health care cost growth target programs is that not all provider entities can be held accountable for total medical expenditures (TME); TME accountability is assessed for a population of patients based on an attributed primary care relationship. When primary care physicians are employed by a health system, their health system employers can be held accountable for TME for an attributed population. However, these attribution methods do not hold hospitals directly accountable for the effects of their rising prices.

Over the last 40 years, the health system has relied on private negotiation of rates between insurers and hospitals to contain hospital prices. The success of this model has depended in part on a balance of negotiating leverage between the parties. The evidence of persistent inpatient hospital commercial price increases well above inflation indicates that this balance increasingly does not exist, and that alternative public policies should be considered.

In this brief, the authors provide guidance to state policymakers seeking to constrain hospital price growth in the commercial market. For this brief, "price" refers to the contractual rates that commercial insurers pay to hospitals, rather than the list or billed price. The authors present an overview of potential strategies intended to address the issues of high and quickly rising hospital prices, along with examples from states that have implemented these strategies. While some of these strategies may mitigate increases in consumer premiums and out-of-pocket costs, consumer spending is not the focus of this brief.[a] It is important to note that many of these strategies are likely to draw significant pushback from hospitals and would require stakeholder engagement before implementation.

KEY STRATEGIES FOR HOSPITAL PRICE ACCOUNTABILITY

1. Publish data on hospital prices and price growth, and "name names"

Description: Publicly sharing hospital-specific payment data is an attempt to hold hospitals accountable through transparency. States can leverage commercial claims data from their all-payer claims databases (or other claims database alternatives). When following this strategy, the state will need to decide whether to report prices at a point in time and/or to report the percentage change in prices over time. The former allows the state to focus on price variation among hospitals and necessitates comparison to other hospitals in the state or to an external benchmark (such as Medicare rates). Comparing prices to an external benchmark such as Medicare can also shed light on whether commercial prices are excessive when compared with other payers and can help a state understand the potential for savings if commercial prices were lower. A longitudinal analysis allows the state to assess growth of hospital prices annually or calculate an average annual growth rate for each hospital individually over time. In either case, the state must ensure that the comparison is valid and accounts for differences in service mix; this can be done through a service-to-service comparison or a market basket comparison that assesses a standardized group of services. To implement and sustain this strategy, the state must have sufficient funding and staff with expertise and analytic capability.

Likely impact on hospital price growth: While there is no evidence that transparency alone reduces variation in prices or slows growth, this strategy can be used to educate and raise awareness, and can be a precursor and motivator for more impactful policies.

State model: In 2015, the Oregon legislature passed Senate Bill 900,[3] later codified as ORS 442.373,[4] mandating an annual public report that displays the amounts commercial insurance companies pay different hospitals in Oregon for common procedures each year. This

[a] For strategies more directly focused on consumer affordability, see the Georgetown University Center on Health Insurance Reforms blog post "Looking Under the Hood: 'Enhanced' Rate Review to Improve Affordability" (https://chirblog.org/looking-under-the-hood-enhanced-rate-review-to-improve-affordability/).

annual dashboard, developed by the Oregon Health Authority, uses data from Oregon's All Payer All Claims reporting program and allows users to compare the median payments for more than 150 different procedures across Oregon's 60 general acute care hospitals and their outpatient clinics.[5] The dashboard also shows the payment variation across procedures within each hospital, and how median payments have changed over time. The dashboard does not identify individual commercial insurers or provide insurer-specific payments and is not a consumer pricing tool.

State model: In Massachusetts, pursuant to M.G.L. c.12C §10,[6] the Center for Health Information and Analysis (CHIA) reports annually on relative prices to examine provider price variation for acute hospitals, chronic care hospitals, behavioral health hospitals, rehabilitation hospitals, and physician groups. In addition, for acute hospitals, CHIA calculates cross-payer statewide relative prices, enabling comparison of acute hospital prices across all commercial payers. CHIA releases results with a data-driven annual publication and produces an interactive relative price dashboard that allows users to explore the data in more detail.[7]

2. Tie the terms of hospitals' certificate of need (CON) and cost and market impact review (CMIR) approvals to the cost growth target value

Description: One preventive strategy to address higher prices charged by health systems with significant market power is requiring advance state notice and review of proposed consolidating transactions and capital investments. States with cost growth targets have an opportunity to tie transaction and facility investment approval terms to their cost growth target values, such as by requiring that future prices do not grow faster annually than the cost growth target value — or some percentage of it, to account for changes in utilization rates.

CMIRs are prospective assessments of the cost and market implications of proposed mergers, acquisitions, contracting affiliations, and other market changes involving health care providers, and can be used to increase scrutiny and accountability to help ensure that such transactions do not result in increased health care cost growth. All state attorneys general have some authority to oversee health care mergers and acquisitions involving health care providers. However, the CMIR process typically involves a separate state agency review of the projected market impacts and can include authority to delay or halt a proposed transaction. These CMIR processes require additional statutory authority.

CONs are state regulatory mechanisms for approving major capital expenditures and projects — including establishment, expansion, construction, renovation, and major medical equipment acquisitions — for certain health care facilities. CON programs primarily aim to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need. Limits on price growth can be added as conditions for CONs that are likely to result in price increases.

Likely impact on hospital price growth: Significant research documents that market power produces higher prices, and that both horizontal[8] and vertical[9] provider consolidation increases prices. Tempering hospital market power by preventing further consolidation and by linking market expansion approval to price growth restrictions can improve hospital accountability for price growth.

State model: In Connecticut, the Office of Health Strategy (OHS) administers the CON program.[10] OHS may review any proposed transactions where health care services are initiated or terminated, or where ownership of a health care facility or large practice is transferred. During this process, OHS may elect to hold a public hearing on any application for a CON, subpoena witnesses, and require the production of records. Approval may be tied to certain conditions or terms related to cost control, patient access, or detailed reporting. A CON application approved in 2024 allowed Yale New Haven Health System's acquisition of Prospect CT's three Connecticut hospitals so long as Yale New Haven Health System constrained the growth in commercial prices to within 0.5% of the cost growth benchmark for the first five years.[11]

State model: In Massachusetts, the Health Policy Commission (HPC) has authority to review and analyze the impact of proposed market changes. The CMIR process ensures transparency of provider actions involving mergers, acquisitions, and other material changes that

are likely to result in a significant impact on cost, quality, or access; on the state's ability to meet the health care cost growth benchmark; or on the competitiveness of the market (M.G.L. c. 6D, §13).[12] The HPC also receives all Determination of Need (commonly known as CON) applications for facility expansions that are submitted to the Department of Public Health and can provide comments as a party of record; these can be extensive and comparable to a CMIR. Following the CMIR process or similar review of Determination of Need applications, the HPC may make recommendations to the Office of the Attorney General, the Department of Public Health, or other state agencies. For example, following recommendations from the HPC, the agreement that allowed Beth Israel Deaconess Medical Center and Lahey Health to merge required a seven-year price growth cap to ensure that spending increases remained below the state's cost growth benchmark.[13]

3. Take direct action on narrower hospital pricing policy issues

States can pursue a series of smaller-scope and more targeted policies if the other six strategies cited in this brief are not feasible at a given time. These strategies are likely to have less financial impact than most of the more systemic approaches. Two examples follow:

- **Ban anti-competitive contracting:** State oversight of provider consolidation focuses primarily on preventing horizontal consolidation (between the same type of organization, e.g., hospitals) and vertical consolidation (across different types of organizations, e.g., hospitals and physician practices) that can make markets less competitive and raise provider prices. In addition to the tools addressing provider consolidation described in Strategy 2, states can seek to address anti-competitive contracting, whereby dominant health care systems and hospitals seek to raise prices by exploiting their market power to demand favorable terms in their contracts with health insurance plans. For example, Nevada passed a law banning "all-or-nothing" contracting, which forces health plans to contract with all providers in a system, often at a higher rate, instead of allowing contracts with some providers in a system.[14]
- **Implement site-neutral payments:** Many routine health care services are safely provided in both hospital outpatient departments and in nonhospital settings, such as physician offices. Commercial prices and patient cost-sharing are generally higher (often twice as high or more) at hospital outpatient sites than in nonhospital settings, in part because of the addition of a hospital facility fee. To limit higher prices resulting from hospital market vertical consolidation, states can require site-neutral payments. This policy mandates the same price for a service irrespective of service delivery location, for certain ambulatory services commonly provided in office-based settings. Several states (most recently Colorado,[15] Connecticut,[16] and Indiana[17]) have established policies to constrain facility fee revenues.

4. Create a complementary hospital price growth target

Description: States with a cost growth target may want to consider setting an additional, complementary target for hospital price growth in the commercial market. This target could be set to the cost growth target value or below it to account for anticipated utilization growth. States will also need to consider which types of hospitals to include in the price growth target; states may consider initially implementing the target with certain types of hospitals, such as acute care hospitals, and later expand the target to other hospital types in order to simplify implementation. While an explicit statutory directive, or even allowance, to set a state target for hospital price growth is ideal, state agencies without either can still pursue a target with existing data collection mechanisms if their overarching statutory charge is to improve patient affordability and/or access. Additional authority to gather data is not required as all-payer claims databases (or other claims database alternatives) provide the necessary data to assess the impact of commercial market hospital prices on spending growth. A target for hospital price growth supports focused analysis of prices and isolates the impact of prices on overall health care affordability.

States implementing this strategy should consider potential consequences for hospitals' financial stability and ability to provide high-quality care if a price growth

target is too low. Further, a price growth target may perpetuate underlying disparities in payment because, in absolute terms, higher-priced providers can continue to increase their rates more (in absolute dollars) than lower-priced providers. Using data to spotlight how prices contribute to access and equity barriers can further generate public support, including from advocacy organizations and employers, for stronger policies.

Likely impact on hospital price growth: To date, no states have implemented this strategy, although it has been a topic of conversation and interest among states participating in the Peterson-Milbank Program for Sustainable Health Care Costs. A hospital price growth target explicitly holds hospitals accountable to a key driver of health care spending — one over which hospitals have significant influence — and would likely have some impact on hospital price growth, although not as much as a statutory cap on price growth. Creating hospital accountability for price growth would help states with cost growth targets meet their total health care expenditure targets, advancing affordability more broadly. As they do with their cost growth targets, states should develop or leverage enforcement mechanisms (e.g., compelling testimony by hospital officials, requiring performance improvement plans, or assessing financial penalties) to enforce compliance with the target to enhance impact.

5. Set a hospital price cap ("reference-based pricing")

Description: Price caps, also referred to as "reference-based pricing," directly limit provider prices, usually as a percentage of Medicare rates, but possibly using another pricing reference. States have many options in price cap design:

- Price caps can be applied to a narrow set of services or to a more comprehensive set of services.
- States may exclude certain hospital types from caps or phase in their participation.
- Price caps can be applied to specific market segments only, such as within a public option program or a state employee health plan, or can be applied more broadly across the insurance market.

If not pursued in conjunction with a price growth cap (see Strategy 6), this strategy should be implemented with a "lesser of" provision that protects against price increases for services where the capped amount is higher than current commercial rates. States will likely need legislative authority to implement price caps and ensure effective oversight and enforcement, although states starting with public employee plans may be able to do so without legislation. While states can implement price caps for the fully insured market through insurance regulation, states can also consider implementing a cap on hospital charges, which would expand the application to the self-insured market. States will need dedicated staff with analytic capabilities to implement this strategy. Consider that setting a low price cap would substantially reduce spending but could disrupt hospital operations and financial status, at least in the near term. On the other hand, a high cap could affect only a small number of hospitals and be ineffective in reducing aggregate spending.

Likely impact on hospital price growth: Because price caps directly impact a key driver of health care spending and spending growth, this strategy has the potential to have a significant impact by directly constraining hospital prices, though the magnitude will depend on the level of the price cap and how broadly caps are applied. States should anticipate that hospitals subject to price caps may look for other places to grow revenue, including raising prices elsewhere and looking for opportunities to grow volume.

State model: Montana's state employee health plan, administered by Montana's Health Care and Benefits Division (HCBD), implemented reference-based pricing for hospital inpatient and outpatient services from 2016 to 2022. Rather than straight price caps, the HCBD negotiated and contracted with each hospital to reimburse at 220%–225% of Medicare rates for inpatient services and 230%–250% for outpatient services. The target reimbursement ranges significantly narrowed price variation for the state employee plan, as the HCBD paid a range of 191%–322% and 239%–611% of Medicare rates for hospital inpatient and outpatient services, respectively, prior to the reference-based pricing agreements. Because several hospitals had to significantly reduce rates, Montana allowed for a three-year transition period for some hospitals to reach the target reimbursement range. An

independent evaluation found that the program generated an estimated savings of $47.8 million over the three state fiscal years from 2017 to 2019.[18] The program ended in 2023 when the state selected a different third-party administrator for the state employee health plan.

State model: Oregon passed legislation in 2017 that prohibits hospitals from charging the state employee plan more than 200% of Medicare rates for in-network hospital facility services and 185% of Medicare rates for out-of-network prices.[19] This price cap applies to only 24 of 62 hospitals in Oregon, as it does not apply to rural or critical access hospitals or certain sole community hospitals.[b] In the first 27 months of implementation, this policy resulted in an estimated $107.5 million in savings for the state, amounting to 4% of plan spending.[20] The analysis also found that all the hospitals subject to this policy remained in network and did not increase their prices for the non-state-employee commercial population to compensate for revenue losses.

State model: Washington State's Health Benefit Exchange oversees the Cascade Care Select public option program. For all Cascade Care Select plans offered in the individual market, the maximum aggregate reimbursement target is 160% of Medicare rates for provider and facility services. Separate targets are set for critical access hospitals, sole community hospitals, and primary care services. The reference price serves as a ceiling for the reimbursement rate that the insurer pays providers in the statewide aggregate for the public option plan. Facilities and providers can be reimbursed at higher rates, as the reference price does not function as a ceiling for any individual facility or provider. While no enforcement mechanism is explicitly outlined in statute, the Washington State Health Care Authority (HCA) can hold carriers accountable for affordability, quality, and value targets outlined in contracts between HCA and the public option carriers. The 2021 and 2022 claims data submitted to HCA's actuarial consultant demonstrated that public option provider reimbursement targets were generally met.[21]

6. Establish a hospital price growth cap

Description: Hospital price growth caps limit how much provider prices can grow each year. This strategy can be pursued as an independent strategy or paired with a hospital price cap (see Strategy 5). States may tie the price growth cap to an economic indicator like the Consumer Price Index or a health care–specific inflation index (e.g., Medicare market basket) so that health care prices do not grow faster than other parts of the economy. States may also choose to set the cap at the cost growth target value or below the target to account for anticipated utilization growth. Price growth caps can be applied at the aggregate level across all of a payer's contracts or for each payer-provider contract. Further, when establishing the price growth cap, states should consider the overall savings goals, along with the anticipated impact on hospital financial status. If the growth cap is too high, the strategy will not effectively contain spending growth. If the cap is set too low, there could be deleterious consequences for the hospitals' financial stability and ability to provide high-quality care. One major risk of price growth caps is perpetuating and exacerbating existing disparities in payment. Adjustments or different caps for different hospitals may be necessary to remedy these payment disparities. States will need legislative authority to implement and enforce this strategy. States will also need to ensure they have the analytic resources and capability for oversight and monitoring activities.

Likely impact on hospital price growth: By directly influencing the growth in hospital prices, price growth caps can be highly effective in constraining commercial

> States can apply Strategies 6 and 7 using existing insurance authority or by creating a new authority to regulate providers. The former approach relies on voluntary action by insurers if the strategy is to be applied to the self-insured market. The latter would allow the state to specify prices paid to hospitals in both the fully insured and self-insured markets.

b Oregon excludes sole community hospitals that are in counties with fewer than 70,000 people and receive at least 40% of their revenue from Medicare.

market spending growth. As mentioned for Strategy 5, the magnitude of this impact will depend on the level of the price growth cap and how broadly it is applied.

State model: In 2010, Rhode Island's Office of the Health Insurance Commissioner (OHIC) implemented affordability standards for all commercial insurers in the state.[22] Among other requirements, the standards limit the average annual price increase rates for both inpatient and outpatient hospital services within each insurer-provider contract. OHIC enforces the hospital price growth cap through health insurer rate review; this mechanism gives state regulators the opportunity to review, and in some cases disapprove or modify, the proposed health insurance rate increases. According to an independent study, the affordability standards were associated with a $55, or 5.8%, net decrease in quarterly total health care spending per commercially insured enrollee, relative to a control population.[23] While it is limited to the fully insured market segment, the cap extended to the self-insured market in practical application by insurers.

7. Prospectively review and approve hospital revenue and/or price growth

Description: Prospective regulator review of hospital revenue and/or price growth can be an effective cost containment measure. This can take the form of a detailed prospective hospital budget review or a more limited review of revenue targets and aggregate prices. This strategy requires statutory authority. To implement this strategy, states annually review hospital submissions from hospitals and health systems. Annual subregulatory guidance is also helpful to provide standard reporting forms and publish state expectations for acceptable revenue and price growth. State regulators could decide to set a hospital-specific cap on net patient revenue growth (or total revenue growth) or a cap on price growth, based either on negotiated prices or on growth in the hospital chargemaster, the collection of standard list prices for hospital services. To implement this strategy, states must have appropriate staff as this process is labor-intensive. Data lag — including claims lag and delays in availability of finalized hospital financial data — can pose challenges in this work.

Likely impact on hospital price growth: States with authority to directly regulate prices or charge growth will have the largest impact on hospital prices and price growth; states with authority to regulate hospital revenue or revenue growth will also likely reduce hospital price growth. Note that states' ability to enforce these regulations (e.g., by requiring price cuts in future years for states that exceed approved revenue targets) will be critical in determining their ability to impact hospital prices.

State model: Vermont hospitals' budgets have been subject to state review since 1983 and regulated by the Green Mountain Care Board (GMCB), an appointed board tasked with controlling health care spending growth, since hospital fiscal year 2013. Annually, the GMCB reviews and establishes budgets for hospitals — excluding specialty hospitals like psychiatric facilities — for their fiscal year beginning October 1.[24] In its orders, the GMCB typically establishes upper limits on both hospital charge growth and growth in net patient revenue (including both fee-for-service payments and any fixed prospective payments) for the year. Enforcement hearings related to the hospitals' performance in the prior budget year are held in late winter or early spring for hospitals with significant budget variances; to increase transparency, the public may comment on and attend meetings during the hospital budget review process. In specific circumstances, the GMCB may modify a hospital's approved budget. Once budgets are approved, hospitals submit quarterly data and performance information to the GMCB so that it may monitor performance. A 2018 study demonstrated that for rates effective January 2013 through calendar year 2019 (filed through July 2018), the total premium rate adjustments made in the rate review process saved Vermonters approximately $108 million, or about 2.8%.[25]

State model: In June 2024, Delaware adopted legislation creating the Diamond State Hospital Cost Review Board, which is tasked with reviewing and regulating hospital budgets to ensure compliance with the state's health care cost growth benchmark.[26] The review board is authorized to collect a wide array of documents from Delaware hospitals annually and assess these submissions for compliance with the state's cost growth benchmark. For hospitals that are noncompliant, the review board will evaluate and approve hospital-developed performance

improvement plans. The review board may approve or modify budgets for hospitals that fail to produce an acceptable plan or sufficiently improve within 12 months.

Additional relevant models: Maryland has a long-established process of setting hospital payment rates, starting in 1971 with the state's All-Payer[c] Rate Setting System, which set fee-for-service prices. Maryland piloted and subsequently implemented a hospital global budget system from 2008 to 2018, and is currently implementing a total cost of care model that successfully reduced hospital spending by an average of $480 per beneficiary per year in the first four years of implementation.[27] Maryland is also participating in the Centers for Medicare & Medicaid Services' States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model,[28] a state total cost of care model that is scheduled to be implemented in six states and may in time create a pathway for improved hospital accountability.

IMPLEMENTATION CONSIDERATIONS

As states consider implementing various hospital accountability strategies, they must also recognize the likely challenges in doing so. First is the challenge of political complexity, as states are likely to face strong resistance from hospitals and possibly other industry stakeholders. Additionally, solutions that target specific segments of the commercial market, such as certain purchasers or hospitals, while easier to implement, may unintentionally shift pressure to other areas. Furthermore, measuring the impact of these strategies on employers, employees, and hospitals is essential but difficult, as it requires comprehensive, accurate data and the ability to track nuanced outcomes. Finally, these strategies are technically challenging to design and to implement well.

None of these challenges justify inaction, but they must be noted.

CONCLUSION

High and fast-growing commercial market hospital prices produce financial hardship for health care purchasers and patients and impede access to needed services. It is vital that states create accountability and enforcement authority for hospitals that significantly contribute to spending growth but currently are not directly accountable to a cost growth target. When deciding which strategy or strategies to pursue, states should consider the desired impact on constraining price growth, the political feasibility of the strategy, and the resources required to implement the strategy. In addition, states should carefully consider which strategies are complementary, or which could be used to promote the implementation of additional, more impactful strategies in the future.

[c] This program applied to fully insured and self-insured plans, Medicaid, and Medicare (under a federal waiver).

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The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations and health equity by collaborating with leaders and decision makers and connecting them with experience and sound evidence. Founded in 1905, the Fund advances its mission by publishing evidence-based publications and *The Milbank Quarterly,* a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization is working to transform US healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. For more information, visit petersonhealthcare.org.

About The Peterson-Milbank Program for Sustainable Health Care Costs

The Peterson-Milbank Program for Sustainable Health Care Costs supports state-led efforts to make health care more affordable for everyone. Starting with setting a target for reasonable cost increases, states across the country are collecting data on their annual health care spending and analyzing it to find the cost growth drivers. With this information, everyone in the state who has a stake in health care can work together to identify community-wide solutions to improve affordability. For more information, visit The Peterson-Milbank Program for Sustainable Health Care Costs.

Milbank Memorial Fund

Using evidence to improve population health