A Behind the Scenes Look at the Latest in Hospital Price Caps

March 24, 2026 at 2:00-3:15 pm ET

The Commonwealth Fund

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Housekeeping

- We will hold questions until after the expert speaker presentations.
- Please use the **"Q&A" function** to submit your questions. Note that you must select to submit a question anonymously.
- All participant lines are muted.
- After the webinar, you will receive a **follow-up email with the webinar recording and slide deck**.

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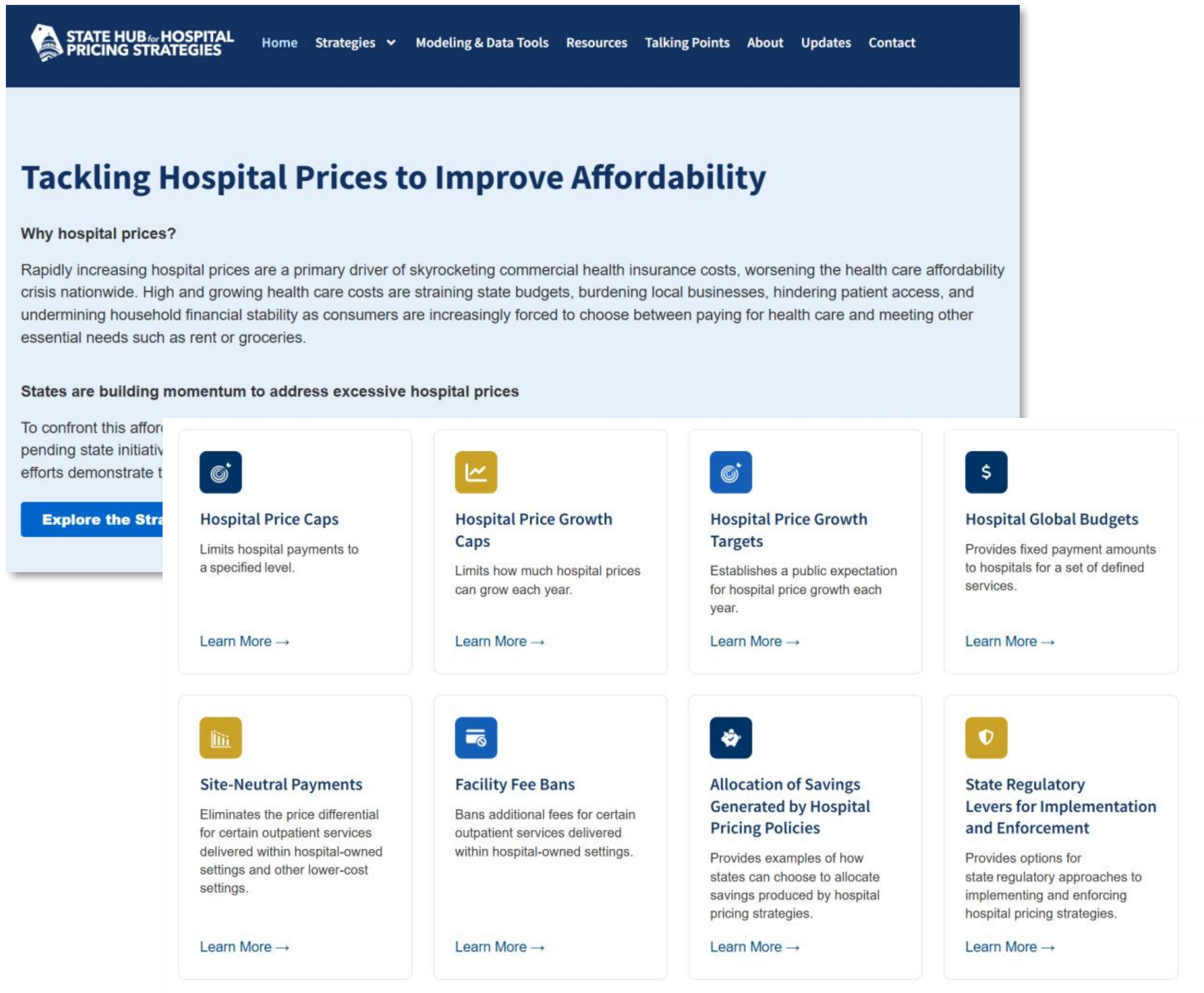
Agenda

1. **Welcome and Price Caps 101**
   Alyssa Vangeli and Caitlin Otter, Bailit Health
2. **Vermont** (Commercial Market-Wide Price Caps)
   Kirk Williamson and Alena Berube, Vermont Green Mountain Care Board
3. **Washington** (School-Based Employee Health Plan Price Caps)
   Evan Klein, Washington Health Care Authority
4. **New Mexico** (State Employee Health Plan Price Caps)
   Colin Baillio, New Mexico Health Care Authority
5. **Maine** (Pending Legislation)
   Trevor Putnoky, Healthcare Purchaser Alliance of Maine
6. **Discussion and Q&A**

STATE HUB for HOSPITAL PRICING STRATEGIES



https://hospitalpricingstatehub.org/

A one-stop shop for state officials to navigate hospital pricing policy design, messaging, and implementation

- ✓ Discussion of regulatory levers for implementation and enforcement
- ✓ Modeling and data tools
- ✓ Ideas for how your state can allocate savings generated by hospital pricing strategies
- ✓ A resource library of selected publications
- ✓ Suggested talking points to effectively socialize your hospital pricing strategy

Hospital Price Caps 101

Caitlin Otter, Bailit Health

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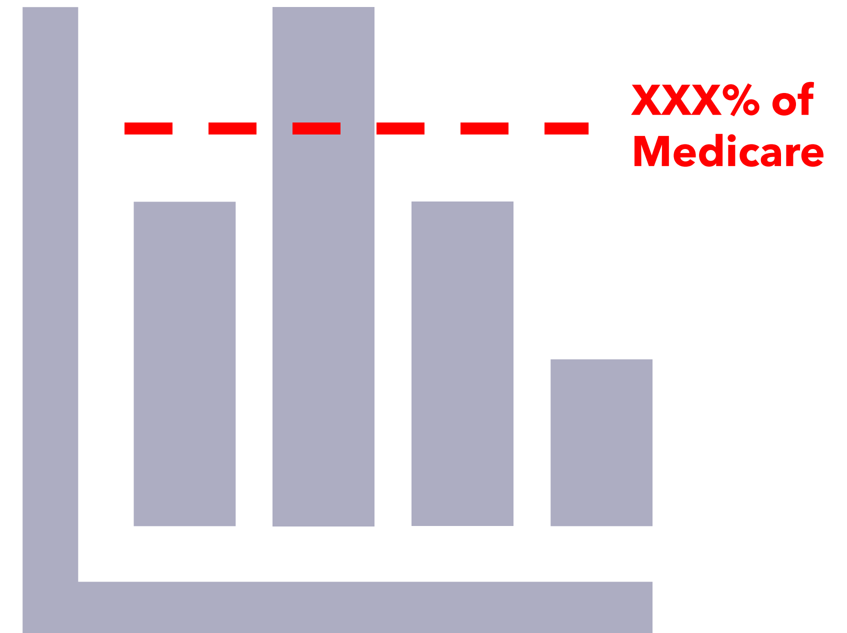
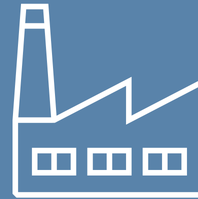
What Are Hospital Price Caps?

- Hospital price caps, also referred to as *payment limits, payment caps,* and *provider-based reference pricing*, directly limit the payment amounts for hospital services.
  - These limits are established in reference to an external payment benchmark, usually a percentage of Medicare.
  - They typically apply to inpatient and outpatient hospital services, although the scope of services may vary.



The Problem – Unaffordable Health Care

- High and rising costs lead to care avoidance, making people sicker.
- As health care costs grow, people have less money for housing, food, and other basic needs.
- Medical debt derails people's financial security.

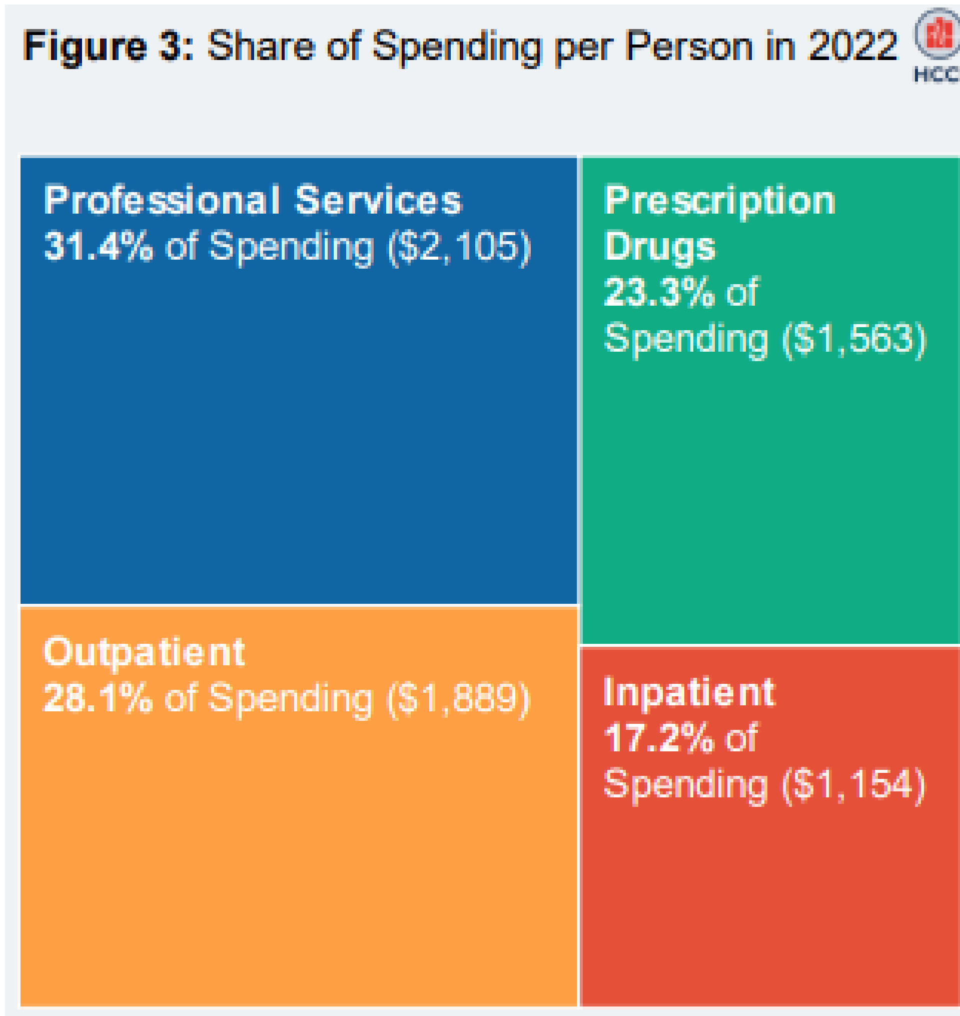


- High health care costs crowd out wages, making it difficult for business to attract and retain employees.
- To cope with rising health care costs, businesses have had to increase prices of goods and services, delay growth opportunities, hold off on hiring, and/or shift to high-deductible plans.

- High health care costs strain state budgets.
- Spending more on health care premiums for state employees leaves fewer resources to invest in other priorities, like education.
- Can lead to underinvestment in important preventive services like primary care.

The Cause – High and Rising Hospital Prices

- Hospital services make up almost half of all commercial spending. **Hospital prices are a central driver** of commercial market spending growth.
  - Increasing prices (more so than utilization) are to blame.
  - Market power, rather than input costs, are what drive high hospital prices in the commercial market.
  - Hospital market power has led to some hospitals being paid way more than others for the same service.



Health Care Cost Institute. 2022 Health Cost and Utilization Report, April 2024.

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The Solution – Hospital Price Caps

- Price caps directly address a primary driver of health care spending and spending growth, making it **one of the most effective tools for controlling hospital prices**.
  - This enables states to lower the overall cost of providing health insurance for employers and enrollees.
    - Lowered premiums for employers, enrollees, and the state
    - Reduced cost-sharing obligations for members who use hospital services
  - By targeting the root cause – inflated hospital prices – price caps strike a balance between ensuring hospitals still have sufficient revenue and making health care more affordable.
- The impact of price caps primarily depends on two factors: 1) the cap level and 2) how broadly the cap is applied.

Hospital Price Caps Design Options

Market Segments:

- Directly to hospital charges, capturing entire commercial market
- Fully insured commercial market
- Within public employee health plans
- Within a public option
- For out-of-network payments

Application to Hospitals:

- Apply to all hospitals
- Exclude certain hospital types
- Vary payment levels for certain hospital types
- Phase in certain hospital types

Implementation and Enforcement:

- Provider rate setting
- Insurance regulation
- Purchasing authority

State Momentum on Hospital Price Caps

Active Implementation
Pre-Implementation
Pending Legislation
Previous Program

Vermont (Commercial Market-Wide Price Caps)

Kirk Williamson and Alena Berube, Vermont Green Mountain Care Board

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Vermont Reference-Based Pricing

Prepared for Bailit Health and the Commonwealth Fund Webinar

March 24, 2026

VERMONT
GREEN MOUNTAIN CARE BOARD

Agenda

1. Background
2. Act 68 (2025) – Reference-Based Pricing (RBP)
3. Considerations

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Vermont Hospital Market Concentration

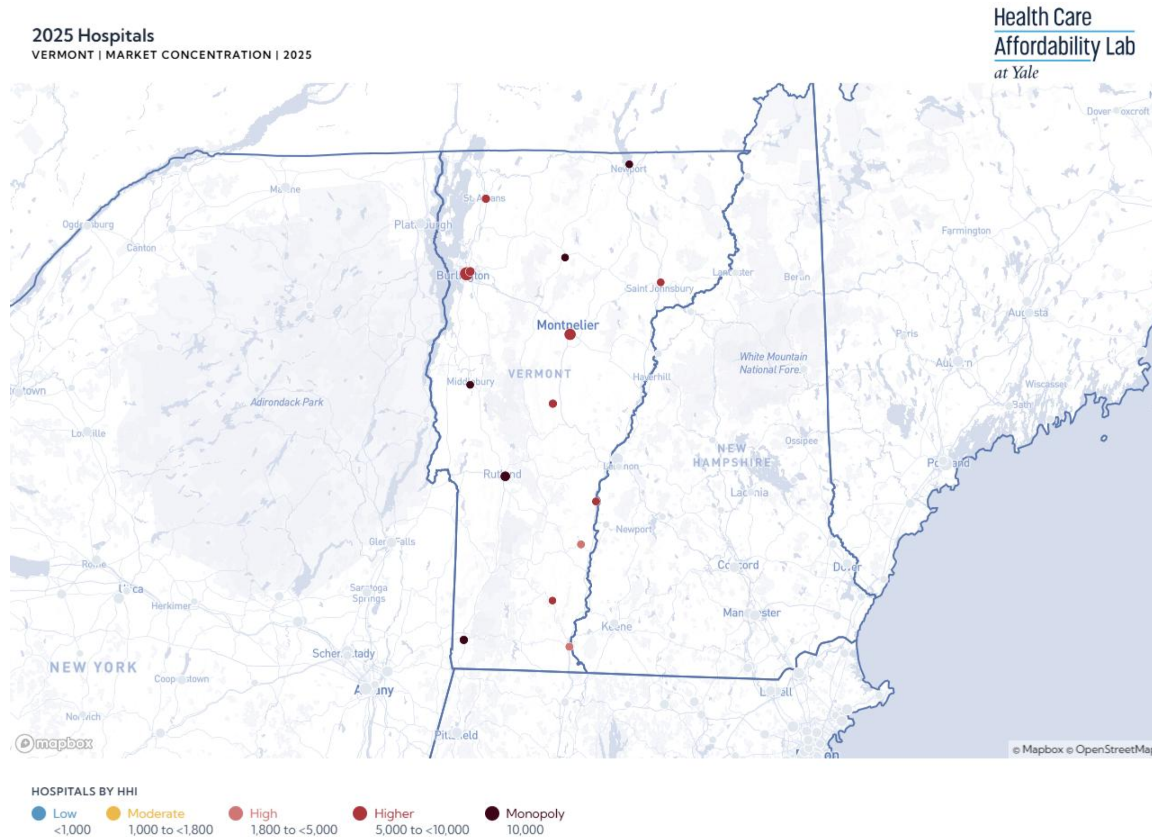


Figure displays a map of Vermont hospital market concentration as of 2025.

- Vermont has extremely high hospital market concentration, which is one of the primary drivers of hospital price increases.
- 15 hospitals (including Dartmouth-Hitchock), average VT hospital market HHI was 7,608 in 2025.*
  - 2 hospitals (13%) – High
  - 8 hospitals (53%) – Higher
  - 5 hospitals (33%) - Monopoly

*Introduction | Evolution of U.S. Hospital Markets | Health Care Affordability Lab at Yale

RAND Hospital Price Transparency Data

Vermont (14th highest priced hospitals relative to Medicare)

- Relative price for inpatient and outpatient services
  - 2020: 254.00%
  - 2021: 269.00%
  - 2022: 283.00%

Vermont (Highest priced hospital-administered commercial drug prices relative to ASP)

- More than **five times** ASP

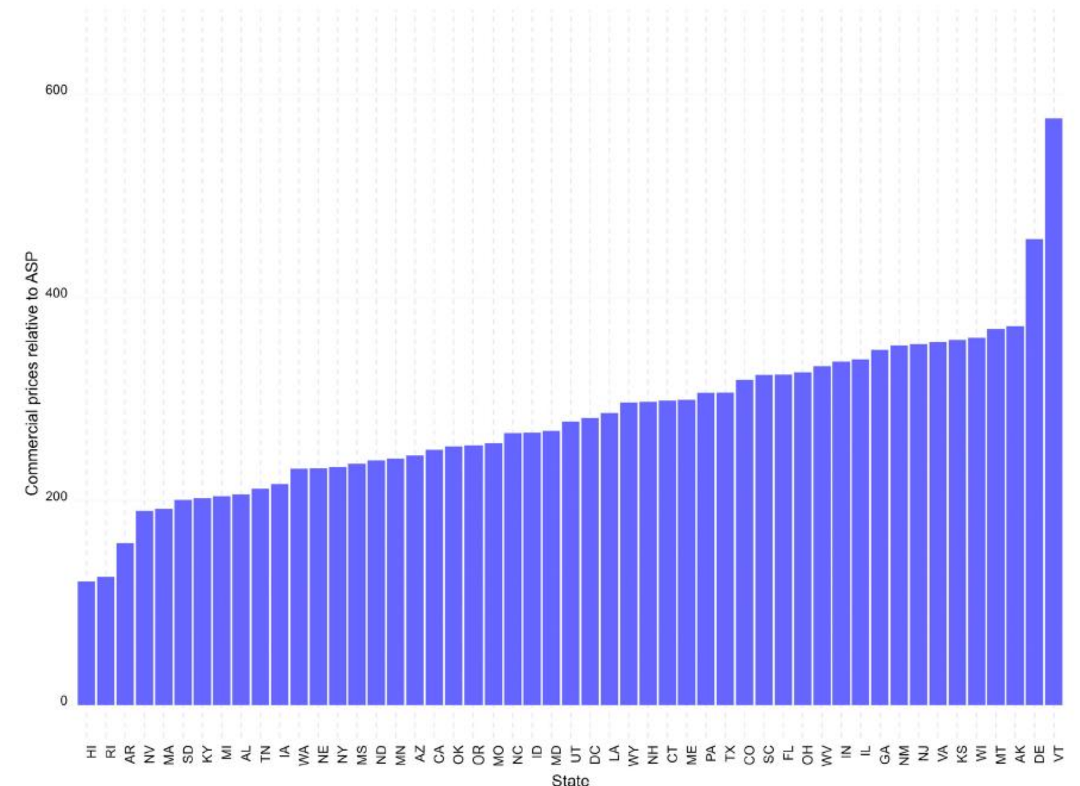


Chart displays state-level hospital-administered drug prices relative to Medicare's Average Sales Price (ASP), which shows Vermont has the highest prices in the country.

The Problem: VT Hospital Prices

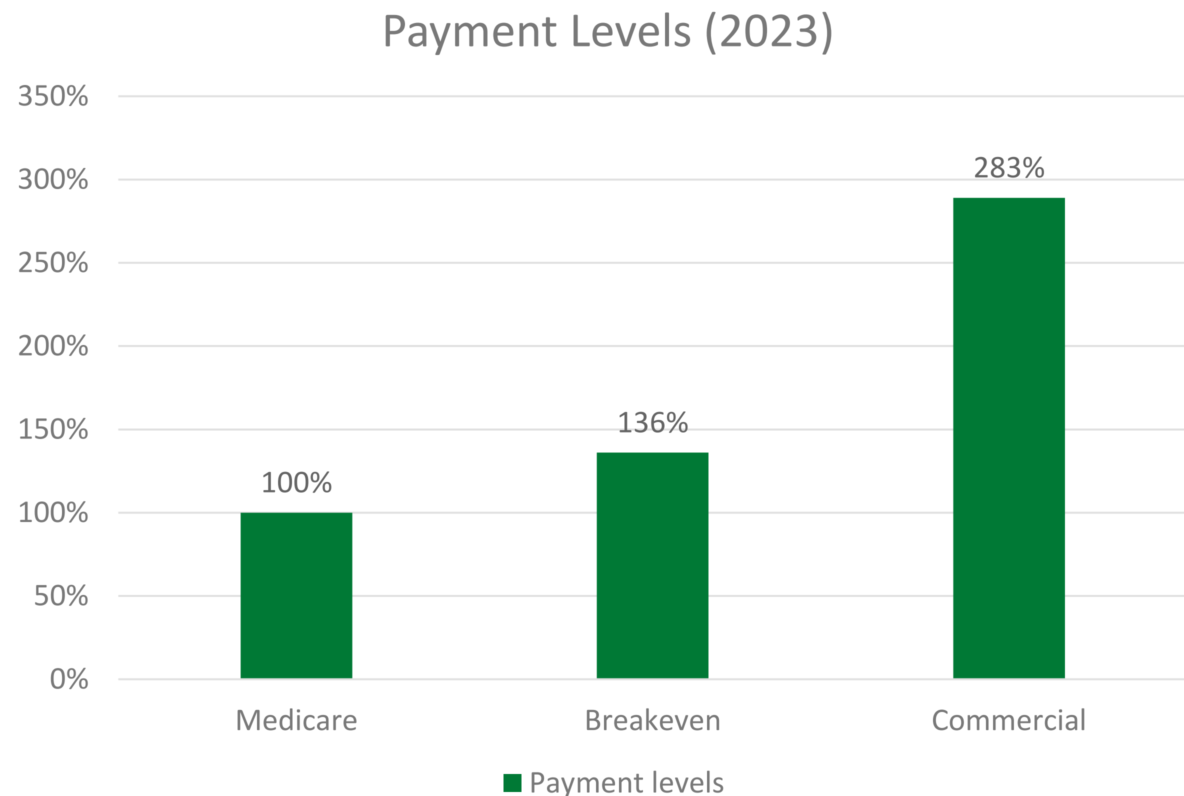


Figure 1: Payment levels received by Vermont hospitals, reflecting that hospitals charge commercial payers roughly 250%-300% of Medicare rates on average for inpatient and outpatient services. It should be noted that the breakeven point is approximately 136%.

- In VT, hospitals charge commercial payers **~283% of Medicare rates** on average, far above what is necessary to cover reasonable costs.
- Rising hospital prices translate directly into **premium increases** and higher out of pocket costs.
- Prices vary widely **within and across Vermont hospitals** for the same service, with no relationship to quality.

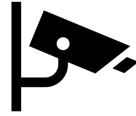
*Aggregated payment levels derived from the NASHP Hospital Cost Tool and the GMCB x HMA Reference-Based Pricing Report.

**Medicare rates are constructed to represent an approximate "break-even" payment rate for efficient hospitals.

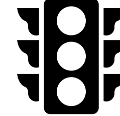
***Breakeven, as shown above, represents the reimbursement rate commercial payers need to pay a hospital to cover all its costs, expressed as a multiple of the Medicare rate to show how much more commercial payers need to pay to ensure a hospital breaks even. (NASHP Hospital Cost Tool)

Act 68 (2025)

Establish reference-based pricing (RBP) for hospital services by FY27



Review and monitor RBPs annually as part of GMCB's hospital budget review process



Identify conditions for modifications or termination of RBPs

Expand to non-hospital services (e.g. primary care)

Act 68 (2025)

- Directs GMCB to **implement hospital reference-based pricing (RBP)** through its **provider rate setting authority, as soon as practicable**, but not later than hospital **FY27.**

- In establishing rates, the Board shall consider:
  - Composition of communities served by the hospital (e.g., population health, demographics, acuity, payer mix, labor costs, social risk factors)
  - Other factors that may affect the costs of providing care
  - Hospital's role in Vermont's health care system
  - Medicare or other benchmarks as appropriate

- Align integration with the hospital budget review process.

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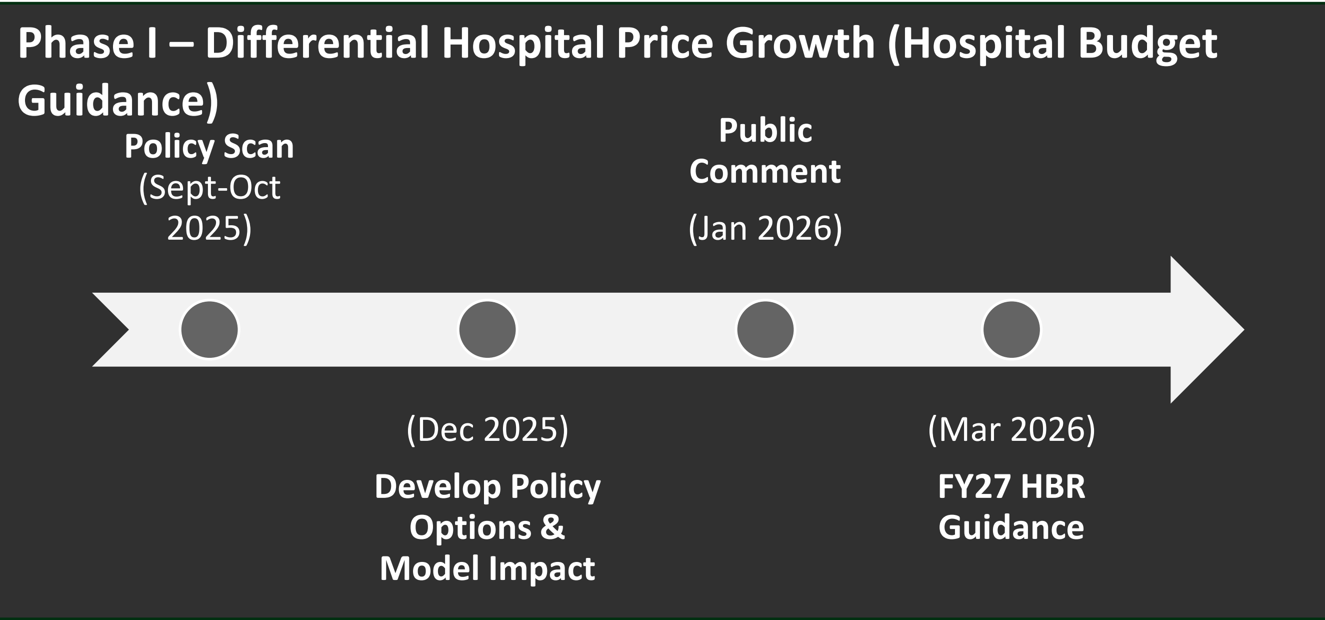
Cross-State Differences in Design

Program	Distinct Features
Vermont Act 68	Mandatory statewide reference-based **maximum allowable payment rates** applied through GMCB's rate-setting authority for all Vermont hospitals; methodology set by rule in 2027, effective HFY28.
Oregon (2019)	State employee plan only; 200% in-network / 185% out-of-network cap; exemptions for rural/CAHs; savings >$100M in first 27 months.
Montana (2016)	State employee plan; direct contracting at % Medicare; initial success ($48M savings) but politically fragile without statutory mandate.
Washington (2021)	Public option ("Cascade Care"); capped hospital reimbursement at 160% of Medicare for participating networks; voluntary participation; expanding to state employee plans.
Maryland Global Budgets (2014 – Present)	All-payer system; only provider-side rate-setting model; hospitals receive **fixed annual revenue** based on standardized prices and volume expectations; includes Medicare waiver; strong incentives to manage population health and quality.

Table 1: Table titled "Cross-State Differences in Design" comparing hospital payment reforms across states. Rows summarize Vermont Act 68, Oregon, Montana, Washington, and Maryland, highlighting differences in scope, use of reference-based pricing or rate caps tied to Medicare, participation requirements, and reported outcomes such as savings or global budget structures.

Phased Approach



Timelines are Contingent Upon:

1. **Expedient, smooth contracting processes, and**
2. **No major challenges in developing data infrastructure.**

Phase II – Hospital Referenced Based Pricing (Rate Setting)

Discovery & Design
(Aug ‘25- Aug ’26)

(Aug ’26 – Dec ‘26)
Model Baseline, Policy Options & Data Validation

Report to Legislature on Implementation Update
(Feb ’26)

Policy & Regulatory Development
(Jan ‘26– Jan ‘27)

FY28 Rate Setting Guidance & HBR Guidance
(Mar ’27)

Figure 5: Horizontal timeline labeled “Phased Approach,” showing Phase I milestones from 2025 to 2026 (policy scan, public comment, and guidance development) and Phase II milestones from 2025 to 2027 (discovery and design, modeling and validation, legislative update, and rate-setting guidance).

Implementation Progress and Resources

Figures display cover pages of GMCB analytical reports and related materials on reference-based pricing.

- Analytic Reports
  - Analysis of Medicare Final Payment Rates in Vermont (Brown University)
  - 2024 Reference-Based Pricing and Data Analysis Report (HMA, GMCB)
- RBP in Vermont Webpage
- Legislative Update
- RFP – Methodological Development and Implementation Support (*forthcoming!*)
- Board Educational Series – *Preparing for Reference-Based Pricing: Medicare Benchmarks, Evidence, and Policy Design*
  - Session 1: Medicare Payment Methods 101
  - Session 2: Vermont's Medicare Payment Landscape – Findings from Brown University
  - Session 3: Blueprints from the Field – State Experiences with Reference-Based Pricing
  - Session 4: Evidence-Based Regulation – Rightsizing Prices and Hospital Budgets

Appropriate level

- Defining “Medicare Price”
    - Fully loaded vs. adjusted Medicare base rate?
    - Cap in the aggregate or at the service level?
    - Extend PPS methodology to the commercial market for CAHs?
- Statewide price cap
    - Contracting support to model how we should phase in the price cap (all at once vs. glide paths, etc.) and over what time horizon
    - Need to consider parallel statewide transformation efforts
- Monitoring
    - Considerations for modifying or terminating price caps
    - Ensuring we are building a system responsive to the environment
    - Connecting price caps to overall health care cost growth and system accountability

Consumer protection

- Ensuring savings flow through to consumers
    - Leveraging GMCB's rate review authority to monitor payer compliance with price caps and the use of any savings achieved under the RBP policy
    - GMCB regulates individual, small, and large group (non-ERISA) health plans offered on the exchange
- Cadence
    - Implications for phasing in payers or implementing statewide all at once
    - Current legislation would start with the QHP market and then expand to state employees and teachers before applying to the entire Vermont commercial market

Hospital-specific considerations

- GMCB regulates all hospital budgets (AHS leading care transformation)
    - 8 of 14 hospitals are critical access hospitals (CAHs), which receive cost-based reimbursement from Medicare
    - Act 68 does not include exemptions
    - Need to consider hospitals that are susceptible, fragile, and have a high public payer mix or low-volume
    - Some hospitals deliver care to vulnerable populations, and we may need to pay more in some areas and for certain services (e.g., primary care, behavioral health)
- Method for determining different caps
    - Service line considerations (access concerns)
    - Community needs
    - Hospital types
    - Balancing simplicity and uniformity with complexity and nuance

Other

- Early in the process
    - What does enforcement and compliance look like (i.e., we are not the payer)?
    - How does this work intersect with statewide transformation goals?
    - How should we build in flexibilities to respond to evolving insurance markets and evolving Medicare and Medicaid payment policies?
    - What are the companion policies we should implement (e.g., upcoding, volume gaming, outsourcing)?

Key Takeaways

Key driver of affordability is high prices for hospital care

Strive for methodological simplicity and predictability to guard against regulatory capture or failure

Adjusted Medicare base price – best approach for apples-to-apples across hospitals, and reduces noise from Medicare-specific policy adjustments

CAHs reimbursed differently than PPS hospitals

Comprehensive approach ensures no squeezing of the balloon: i.e. apply methods in aggregate and at the service level

RBP does not prevent against volume gaming, requiring complementary approach (e.g. hospital global budgets)

Thank You!

GMCB Staff Contacts

- *Alena Berube*, Director of Policy (alena.berube@vermont.gov)
- *Kirk Williamson*, Project Director, Affordability and Pricing (kirk.williamson@vermont.gov)

Accessibility Requests

To receive this information in an alternative format or for other accessibility requests, please contact:

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Washington
(School-Based Employee Health Plan Price Caps)

Evan Klein, Washington Health Care Authority

bailit health

Price Cap Webinar

Evan Klein
Special Assistant for Legislative and Policy Affairs

March 25, 2026

Washington State Health Care Authority

Topics for discussion

- Washington public employee access and affordability
  - Why reference pricing?
  - Summary of policy
  - Rulemaking and compliance guide
  - Lessons learned
- Questions

Washington State Health Care Authority

Why did Washington pursue reference-based pricing (RBP)?

- Recent contract termination notices by large health systems
- Hospital services have largest growth in claims cost and impact on premiums
- Employee benefits rates grew by ~20% from 2021–2024
- WA, OR, and other states have found success with reference pricing to contain costs
- Reimbursement for primary care and behavioral health services lag significantly behind hospital reimbursement, despite benefits of preventive care access

* Rate of growth refers to bid rates, inclusive of fully-insured and UMP plans and averaged across PEBB and SEBB

Summary of policy
RCW 41.05.028

- Applies to fully insured and self-funded medical plans covering ~700,000 public and school employees
- Caps carrier reimbursement for inpatient/outpatient (IP/OP) acute care hospital services at 200% of Medicare, beginning in 2027
  - Sets cap for children's hospitals at 150%/190% of Medicaid IP ratio of costs-to-charges (RCC)
  - Exempts non-system critical access hospitals (CAHs) and sole community hospitals (SCHs)
  - Hospital reimbursement caps apply only to facility charge
- Caps out-of-network (OON) reimbursement for acute care hospitals at 185% of Medicare
  - Lower OON % of Medicaid IP RCC caps for children's hospitals

Summary of policy, cont.

Requires primary care and non-facility behavioral health services be reimbursed at or above 150% of Medicare.

- Requires all carriers take into account changes in reimbursement in rate development
- Requires reports by HCA in 2030 and 2034 on impacts of legislation

Washington State Health Care Authority

Projected impacts

- Anticipate 2027 enrollee premiums to be reduced by 2–3% relative to levels if bill were not in effect
- Controls hospital unit cost trends in future years
- Reduce state expenditures by nearly $200 million over next 4 years
- Increase reimbursement for behavioral health services by over $20 million annually

Implementation progress

- **Adopted rules, effective January 1, 2027**: Chapter 182-40 WAC, PEBB/SEBB reimbursement methodology requirements
  - Reference price methodology
  - Enforcement
  - Balance billing protections
  - Reporting requirements
- Permits recoupment of any hospital overpayments and fines for multi-year noncompliance
- Published a compliance guide
  - hca.wa.gov/assets/pebb/peaa-compliance-guide-2027.pdf

Washington State Health Care Authority

Lessons learned – compliance

- How does your state want to manage enforcement?
  - Claims level
  - Statewide aggregate
  - Hospital aggregate
  - Hospital service category (e.g., IP vs. OP)
- Washington is starting with enforcement for aggregate IP and OP services separately *by hospital*
- What Medicare benchmark to use?
- Should value-based purchasing (VBP) be included in an RBP cap?

Lessons learned – balance billing

- Should ensure facilities cannot balance bill patients for in-network services
- If establishing caps on OON facility reimbursement, need to consider intersection with No Surprises Act or state balance billing laws
  - Will RBP OON rate be required for emergency services vs factor in dispute resolution?
  - Being explicit in state law or rules can avoid payer and provider confusion

Lessons learned – ‘low volume’ services

- Is Medicare an appropriate reference for maternity or children’s health care services?
- What alternative reference prices could be utilized and what are the trade-offs?
  - TRICARE
  - Medicaid fee schedule
  - Medicaid RCC
  - Other?
- If establishing RBP for professional services, need to consider what Medicare doesn’t reimburse for (ex. behavioral health)

Questions?

Materials

- Access and affordability homepage
  - hca.wa.gov/about-hca/programs-and-initiatives/public-employees-benefits-board-pebb-program/public-employee-access-and-affordability
- Program rules
  - hca.wa.gov/assets/103P-25-24-066.pdf
- Compliance guide
  - hca.wa.gov/assets/pebb/peaa-compliance-guide-2027.pdf
- FAQ
  - hca.wa.gov/assets/program/pebb-sebb-access-affordability-faq.pdf

Contact

- Evan Klein
  - Special Assistant for Legislative and Policy Affairs
  - Evan.Klein@hca.wa.gov

Washington State Health Care Authority

Appendix

Primary care

- Strong narratives and client stories about access challenges
- State set primary care expenditure target in 2022*
  - Goal of spending 12% of total health care expenditures in WA on primary care
  - 2022 WA-APCD analysis showed only ~5-6% of spend being towards primary care.
- Cost Board recommended adoption of policies to increase primary care expenditure, including through reference pricing

Primary care reimbursement for PEBB/SEBB, on average, is at 158% of Medicare as of SFY 2025.

* RCW 70.390.080

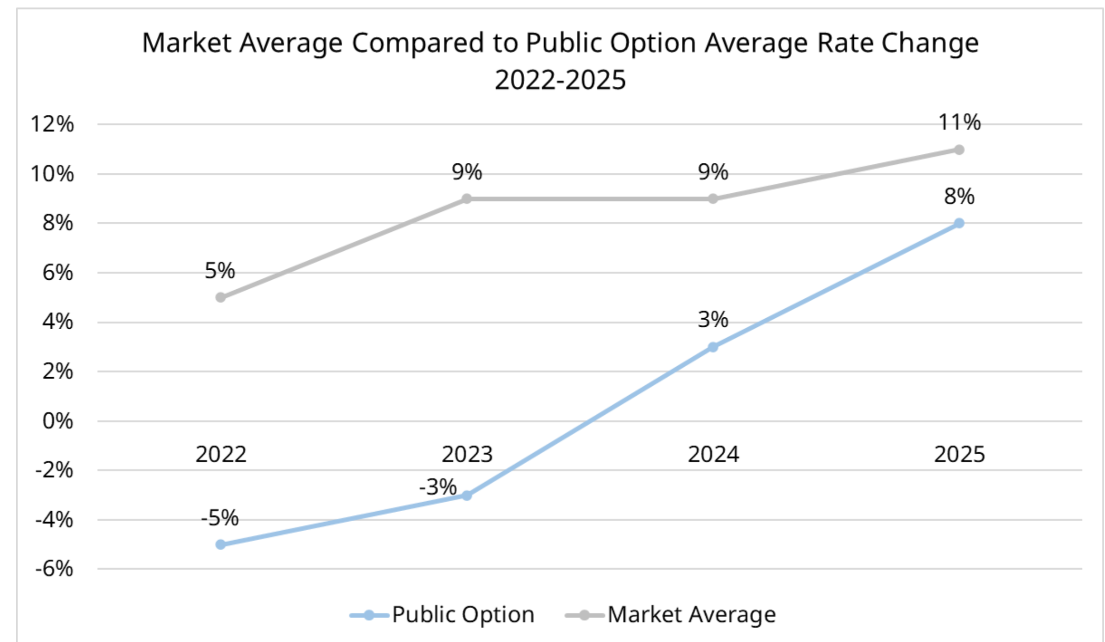
Behavioral health

- Access challenges well documented
- Significant investments in Medicaid behavioral health reimbursement over past 4+ years in WA
- 2024 WA Insurance Commissioner Affordability Report Findings:
  - Inpatient mental health services: 142% of Medicare
  - Outpatient mental health services: 197% of Medicare
  - **Professional fees: 88% of Medicare**

Non-facility behavioral health reimbursement for PEBB/SEBB, on average, is at 113% of Medicare as of SFY 2025.

Success of existing affordability program

- Washington's Cascade Select Program
  - Individual market public option
  - Enacted in 2019, with first plans offered in 2021
  - Caps payment for all services, in aggregate, at 160% of Medicare
    - CAH/SCH must be at or above 101% of cost
  - Statewide access by 2025 and lowest cost silver plan in 31 counties



Washington State Health Care Authority

New Mexico
(State Employee Health Plan Price Caps)

Colin Baillio, New Mexico Health Care Authority

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MEDICARE REFERENCE-BASED PRICING IN NEW MEXICO'S STATE EMPLOYEE HEALTH BENEFITS PLAN

COLIN BAILLIO, HEALTH CARE COVERAGE INNOVATIONS DIRECTOR

INVESTING FOR TOMORROW, DELIVERING TODAY.

MISSION

We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

VISION

Every New Mexican has access to affordable health care coverage through a coordinated and seamless health care system.

GOALS

LEVERAGE purchasing power and partnerships to create innovative policies and models of comprehensive health care coverage that improve the health and well-being of New Mexicans and the workforce.

BUILD the best team in state government by supporting employees' continuous growth and wellness.

ACHIEVE health equity by addressing poverty, discrimination, and lack of resources, building a New Mexico where everyone thrives.

IMPLEMENT innovative technology and data-driven decision-making to provide unparalleled, convenient access to services and information.

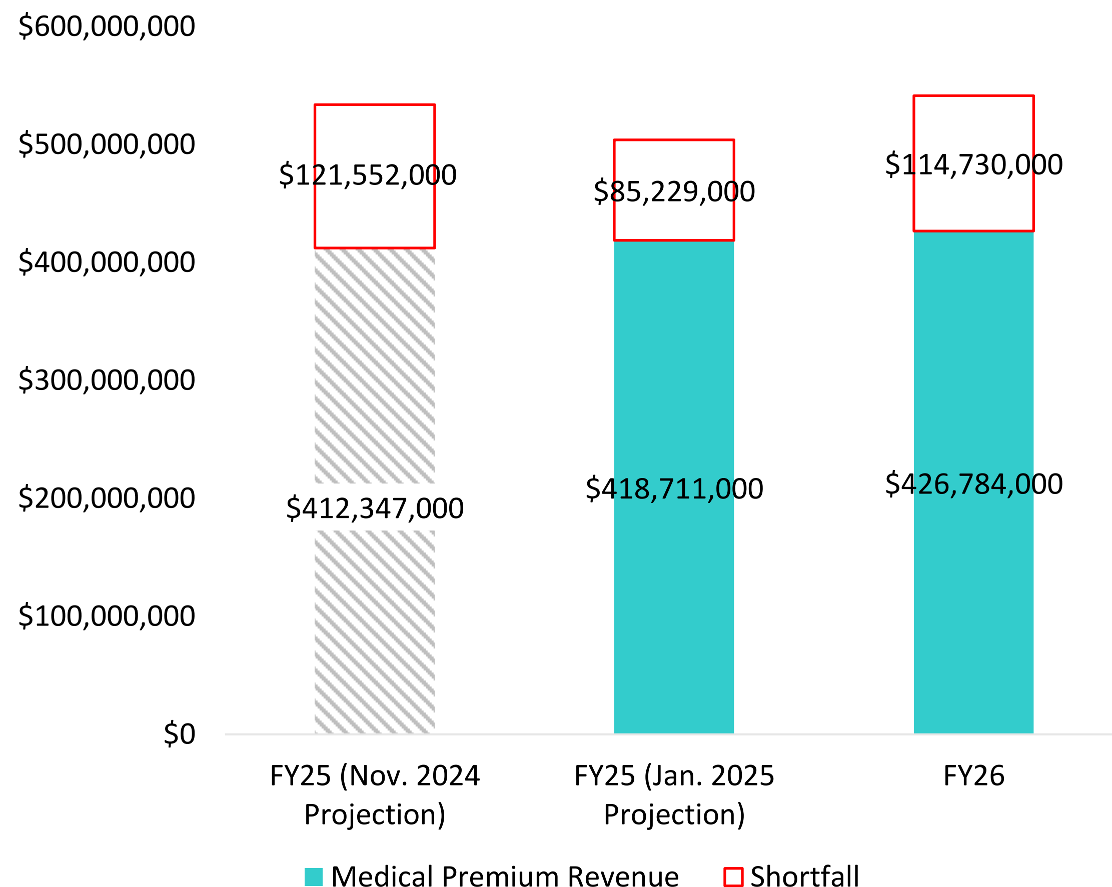
THE NEW MEXICO HEALTH CARE AUTHORITY OFFICIALLY LAUNCHED IN JULY 2024

- Legislation passed in 2024 brought Medicaid, behavioral health, Health Insurance Marketplace affordability programs, health facility regulation, state employee benefits, and many other health-related programs under one roof.
- The purpose of creating this consolidated agency was to leverage state purchasing power and improve outcomes.

HCA WAS TASKED WITH REFORMING STATE BENEFITS

The state benefits program provides coverage to more than 60,000 New Mexicans who are state/local government workers and their dependents.

- **Solvency Issues:** The program arrived with a growing budget deficit.
- **Rate Increase Affordability Issues:** Rates would have to increase 30% to be actuarially sound.
- **Structural Affordability Issues:** On average, the state contributed just 65% of the premium, due to tiering structures that had not been adjusted for nearly 20 years.
- **Cost Issues:** Growing outpatient costs; hospital prices nearly 300% of Medicare.
- **Limited Plan Choice:** Only 3 medical plan options with minor differences in benefits.



SB 376 ADDRESSES LONGSTANDING ISSUES

- **Solvency Issues:** Mandated actuarially sound rates and appropriated funds to ensure sufficient revenue could be raised.
- **Rate Increase Affordability Issues:** Limited underlying rate increases to 20% in FY26 by implementing reference-based pricing.
- **Structural Affordability Issues:** Reduced the employee share of premiums to 20% and created affordability programs for lower income state employees.
- **Cost Issues:** Authorized reference-based pricing and prohibited balance billing.
- **Limited Plan Choice:** Required HCA to expand plan choices.

ALBUQUERQUE JOURNAL | jrnl+

Senate approves bill changing state's approach to employee health care premiums

HEALTH CARE AUTHORITY

REFERENCE BASED PRICING WAS KEY TO THE SUCCESS OF SB 376

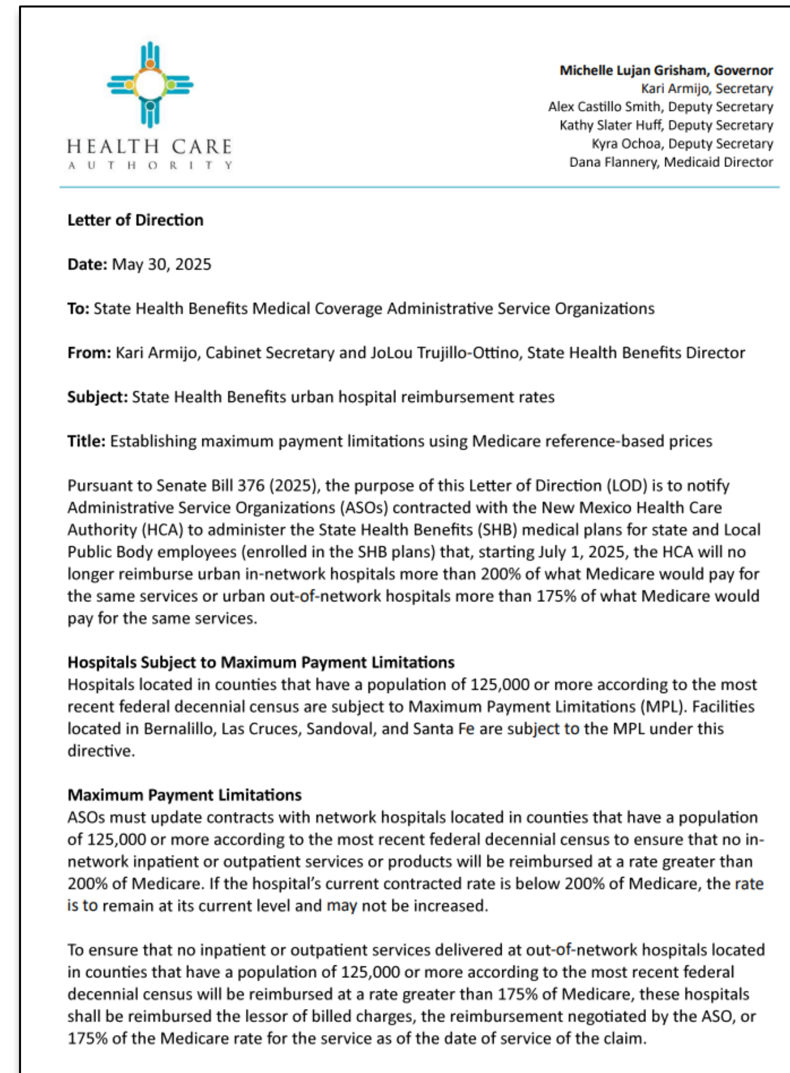
The state could not afford these reforms without addressing underlying costs.

By pairing reasonable and evidence-based cost containment measures like reference-based pricing with member affordability, we were able to build legislative support for reform.

Despite a 20% rate increase, the vast majority of state employees experienced a premium decrease.

HCA'S REFERENCE BASED PRICING METHODOLOGY

- Maximum Payment Limitations:
  - 200% of Medicare in-network; 175% of Medicare out-of-network
  - Services currently priced under 200% of Medicare remain at existing levels
- Applies to inpatient and outpatient hospital care
- Limited to hospitals in urban counties



HEALTH CARE
AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Letter of Direction

Date: May 30, 2025

To: State Health Benefits Medical Coverage Administrative Service Organizations

From: Kari Armijo, Cabinet Secretary and JoLou Trujillo-Ottino, State Health Benefits Director

Subject: State Health Benefits urban hospital reimbursement rates

Title: Establishing maximum payment limitations using Medicare reference-based prices

Pursuant to Senate Bill 376 (2025), the purpose of this Letter of Direction (LOD) is to notify Administrative Service Organizations (ASOs) contracted with the New Mexico Health Care Authority (HCA) to administer the State Health Benefits (SHB) medical plans for state and Local Public Body employees (enrolled in the SHB plans) that, starting July 1, 2025, the HCA will no longer reimburse urban in-network hospitals more than 200% of what Medicare would pay for the same services or urban out-of-network hospitals more than 175% of what Medicare would pay for the same services.

Hospitals Subject to Maximum Payment Limitations
Hospitals located in counties that have a population of 125,000 or more according to the most recent federal decennial census are subject to Maximum Payment Limitations (MPL). Facilities located in Bernalillo, Las Cruces, Sandoval, and Santa Fe are subject to the MPL under this directive.

Maximum Payment Limitations
ASOs must update contracts with network hospitals located in counties that have a population of 125,000 or more according to the most recent federal decennial census to ensure that no in-network inpatient or outpatient services or products will be reimbursed at a rate greater than 200% of Medicare. If the hospital's current contracted rate is below 200% of Medicare, the rate is to remain at its current level and may not be increased.

To ensure that no inpatient or outpatient services delivered at out-of-network hospitals located in counties that have a population of 125,000 or more according to the most recent federal decennial census will be reimbursed at a rate greater than 175% of Medicare, these hospitals shall be reimbursed the lessor of billed charges, the reimbursement negotiated by the ASO, or 175% of the Medicare rate for the service as of the date of service of the claim.

IMPLEMENTATION

- Developed and implemented program within 4 months of SB 376 being signed into law
- Worked carefully with carrier partners on implementation
- Implemented prohibition on balance billing in the RBP program
- Released guidance in May 2025
- Projected to save nearly $40 million in current fiscal year

LOOKING AHEAD

- **Health Care Authority**
  - Developing RBP monitoring framework
  - Preparing for how to disincentivize upwards pressure on services under 200% of Medicare
  - Exploring strategies to mitigate "cost shifting" to other insurance markets
  - Implementing new laws that give HCA oversight of major health care mergers and acquisitions and facility fees

Passage of HB 47 (2026)

- Following the success of SB 376, the NM legislature passed HB 47 to expand key provisions to insurance for public educators
  - Requires reference-based pricing
  - Requires agencies to cover 80% of the premium
  - Study of merging public school employees and state employees into a single insurance program

THANK YOU!

COLIN BAILLIO
HEALTH CARE COVERAGE INNOVATIONS DIRECTOR
NEW MEXICO HEALTH CARE AUTHORITY

Maine (Pending Legislation)

Trevor Putnoky, Healthcare Purchaser Alliance of Maine

bailit health

HOSPITALS ARE THE LARGEST COMPONENT OF HEALTH CARE SPEND

Total Health Care Expenditures in Maine, 2020

Home Health Care, 3%
Durable Medical Equipment, 1%
Other Professional Services, 3%
Dental Services, 4%
Nursing Care Facilities and Continuing Care Retirement Communities, 5%
Other Health, Residential, and Personal Care, 12%
Drugs and Other Non-durable Products,...
Physician and Clinical Services, 21%
Hospital Services, 39%

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). National Health Expenditure Data: Health Expenditures by State of Residence, August 2022.

PER CAPITA HOSPITAL SPENDING IN ME IS >$4,500

Hospital | Physician and Clinical | Drugs and Non-durables

$5,000
$4,000
$3,000
$2,000
$1,000
$0

$4,687
$2,492
$1,432

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). National Health Expenditure Data: Health Expenditures by State of Residence, August 2022. and Federal Reserve Bank of St. Louis. (2024). Real Median Household Income in Maine.

HOSPITAL SEPNDING GROWTH EXCEEDS WAGES + INFLATION

Maine Hospital Expenditures — Annual Inflation — Maine Median Household Income

180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
-20%

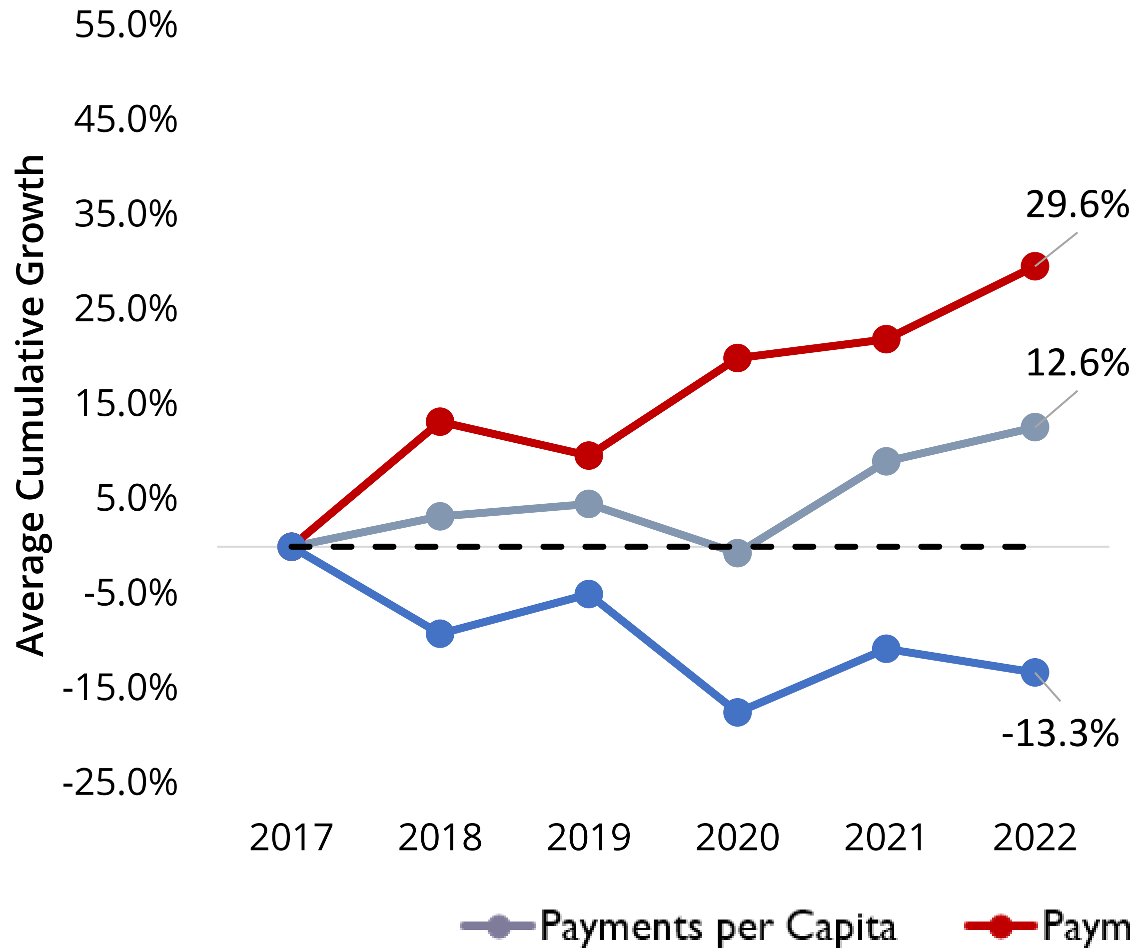
2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

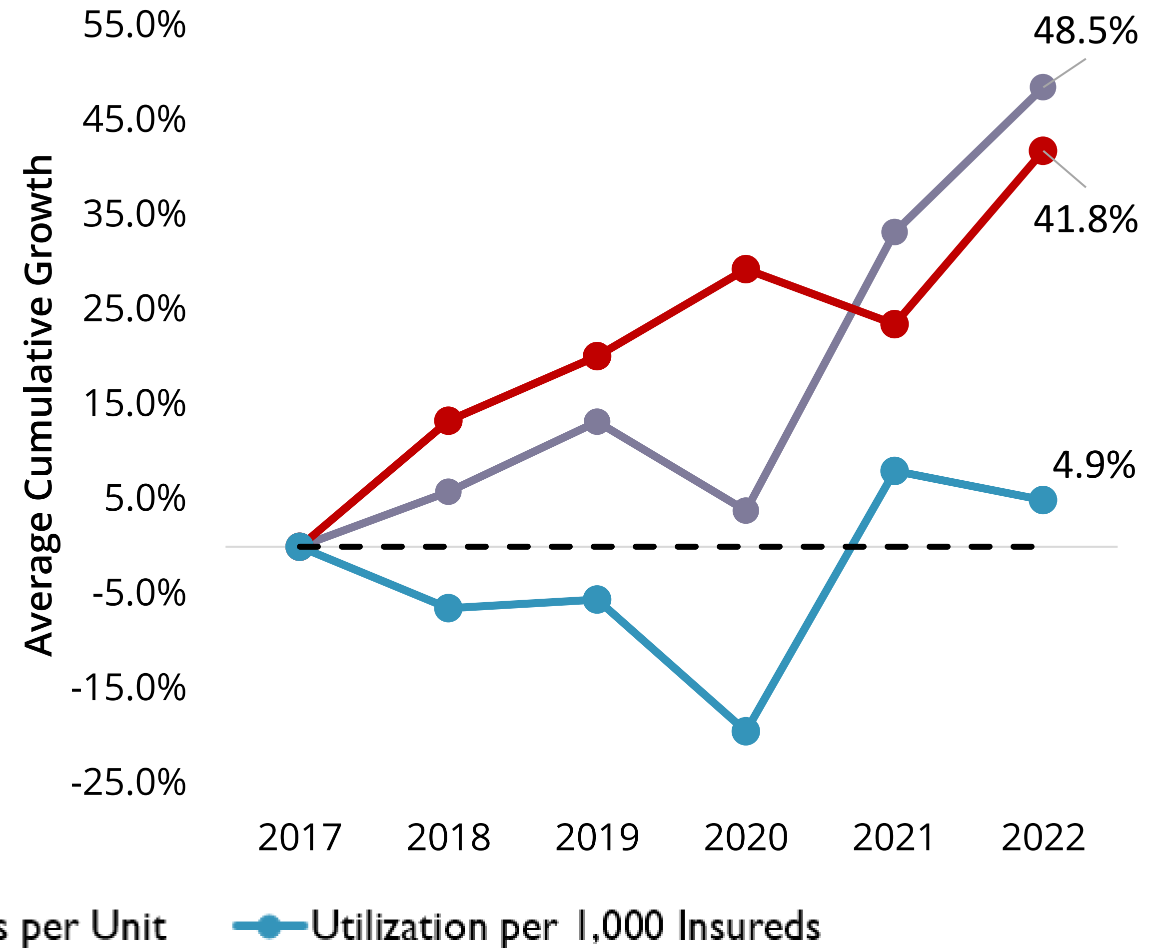
164%
46%
25%

Per capita hospital expenses in Maine have significantly outpaced national inflation and Maine households' median income.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). National Health Expenditure Data: Health Expenditures by State of Residence, August 2022; Federal Reserve Bank of Minneapolis. (2024). Consumer Price Index 1913-.. and Federal Reserve Bank of St. Louis. (2024). Real Median Household Income in Maine.

PRICE DRIVES SPENDING GROWTH IN THE COMMERCIAL MARKET





Source: Maine Health Data Organization. (2024). Hospital Services Payments and Utilization Dashboard

PRICES AT THE LARGEST ME HOSPITALS ARE AMONG THE HIGHEST IN THE US

Standardized Price Per Inpatient Stay

MMC: 88th percentile

EMMC: 82nd percentile

National Median: $22,947

$34,878

$15,196

$40,000
$30,000
$20,000
$10,000
$0

Maine Med Ctr
Eastern Maine Med Ctr
Central Maine Med Ctr
A.R. Gould Hosp
Franklin Memorial Hosp
Inland Hosp
St. Joseph Hosp
Penobscot Bay Med Ctr
MaineGeneral Med Ctr
Southern Maine Med Ctr
Mercy Hosp
Maine Coast Hosp
York Hosp
Mid Coast Hosp
Cary Med Ctr
Northern Maine Med Ctr
St. Mary's Regional Med Ctr

Source: RAND (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. Adapted from Bailit Health.

LD 2196: WHERE WE STARTED

Beginning 1/1/28 . . .

- Inpatient/Outpatient service price caps at 200% of Medicare
  - Exceptions: Critical Access hospitals and "financially distressed" hospitals, as determined by the Office of Affordable Healthcare
- Hospital facility price growth ceiling equal to Medicare's inpatient prospective payment system hospital market basket
- Behavioral health and primary care service price floors at 110% of Medicare
- Limits on prior authorization for chronic condition patients
  - Approved PA not required to be renewed for 2 years following initial approval unless a new treatment protocol is introduced

LD 2196: AMENDED AND PASSSED BY COMMITTEE

- ~~Inpatient/Outpatient service price caps at 200% of Medicare~~
  - ~~Exceptions: Critical Access hospitals and "financially distressed" hospitals, as determined by the Office of Affordable Healthcare~~ REMOVED
- Hospital facility price growth ceiling equal to Medicare's inpatient prospective payment system hospital market basket
  - AMENDED: Applies only to the individual/small group markets (beginning 1/1/27) and the State Employee Health Plan (beginning 1/1/28)
  - AMENDED: Acute care hospitals with standardized commercial inpatient prices below the first quartile may exceed the benchmark by 1%
- Behavioral health and primary care service price floors at 110% of Medicare
  - AMENDED: Price floors will increase over time until they reach 150% of Medicare in 2034
- ~~Limits on prior authorization for chronic condition patients~~
  - ~~Approved PA not required to be renewed for 2 years following initial approval unless a new treatment protocol is introduced~~ REMOVED
- ADDED: Out-of-network price caps at each hospitals' median billed/collected commercial rates for all commercial plans; median benchmarked to Medicare marketbasket at the date of enactment

LESSONS LEARNED

- The Office of Affordable Healthcare, which the Legislature created in 2021 to identify policies to advance affordability, was an enormous asset in moving this policy forward. Viewed by many legislators as an impartial, research-based entity, OAHC drafted the bill, supplied research and analysis to support the policy, and played a key role in addressing concerns from legislators.

- Consumers and purchasers working together was a powerful combination. Consumers for Affordable Healthcare and the Healthcare Purchaser Alliance both talked to legislators, wrote editorials, and ground softening.

- Underlying market dynamics were important considerations for legislators. Legislators have traditionally been very concerned about hospitals' financial challenges, perhaps even more so given the well-publicized federal cutbacks they are facing. But there is also an increased sense of urgency among legislators to address the healthcare affordability crisis facing Maine consumers and businesses, with premiums for the small group market increasing 17.5% in 2026 and individual premiums increasing 23.9%.

- Legislators wanted to do *something*. Starting with a bold policy didn't end up leading to defeat, as some expected. Instead, legislators moderated the policy while still taking a meaningful step forward.

Discussion and Q&A

Facilitated by Alyssa Vangeli, Bailit Health

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