CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

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Hospital Payments Caps Impact on Prices and Spending

Lessons from the Oregon State Employee Plan

Roslyn C. Murray

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Submitted to the House Appropriations Committee
Washington State Legislature

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Chairman Ormsby, Vice Chair Gregerson, Vice Chair Macri, Ranking Member Coutoure, and members of the committee, thank you for the opportunity to provide written testimony on the potential impact of hospital price caps, referencing my work evaluating the Oregon State Employee Plan's hospital payment cap policy. My name is Roslyn Murray, I am an assistant professor of Health Policy at the Brown University School of Public Health and a research faculty member at the Center for Advancing Health Policy through Research (CAHPR).

Hospital prices are the main driver of rising health care spending in the United States.[1, 2, 3] Spending on hospital care accounted for $1.5 trillion in 2023.[4] In the commercial insurance market, hospitals leverage their market power to sustain high prices, a situation worsened by consolidation.[5, 6] Over the past few decades, studies have shown that hospital prices in the commercial market have increasingly diverged from Medicare rates, which are generally considered a breakeven level for efficient hospitals.[7] Inpatient facility prices rose from 110% of Medicare rates in the late 1990s to 254% in 2022.[8, 9] This growing cost burden is felt by individuals and families in the U.S. through higher premiums, increased out-of-pocket spending, stagnant wages, and job losses, especially for low-wage workers.[10, 11] Additionally, the ability of certain providers to command high prices has contributed to a divide between "have" and "have-not" hospitals, where the former can build substantial reserves, while the latter struggle to maintain core operations.[12, 13]

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[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).
[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).
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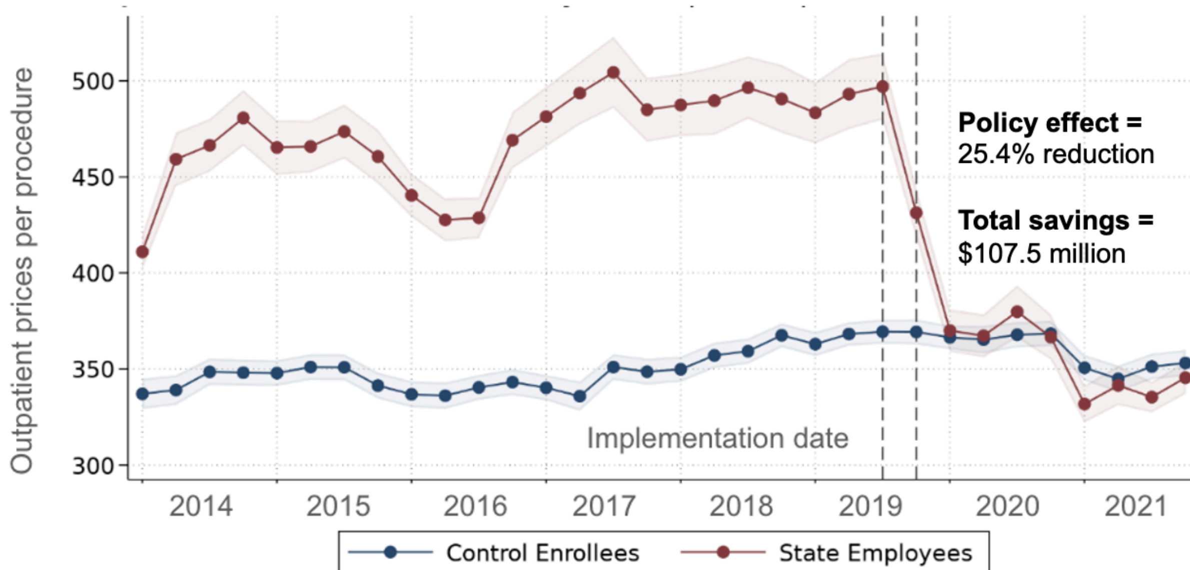
[12] Kane N, Berenson R, Blanchfield B, Blavin F, Arnos D, Zuckerman S. Why policymakers should use audited financial statements to assess health systems' financial health. Journal of Health Care Finance. 2021 Aug 5.
[13] Blavin F, Kane N, Berenson R, Blanchfield B, Zuckerman S. Association of Commercial-to-Medicare relative prices with health system financial performance. InJAMA Health Forum 2023 Feb 3 (Vol. 4, No. 2, pp. e225444-e225444). American Medical Association.

High and rising hospital spending also places significant fiscal pressure on health care purchasers, including state and municipal health plans. In response to budgetary challenges, Oregon introduced legislation in 2017 to cap hospital facility prices for its state employee plan. The cap took effect in October 2019 and prohibits the state's carriers from paying in-network hospitals more than 200% of Medicare rates for services provided to members of the state employee plan.[14] Services received at out-of-network hospitals cannot exceed 185% of Medicare rates. Twenty-four of the state's large, urban hospitals are subject to this legislation.

In evaluating the policy, my colleagues and I found that outpatient facility prices decreased by 25%, while inpatient facility prices dropped by 3%, resulting in $107.5 million in savings for the state over the first two years and three months—about 4% of total plan spending (Figure).[15] In related work, my colleagues and I found that enrollees in higher cost-sharing plans experienced a 9.5% reduction in out-of-pocket spending, with only slight increases in service use.[16] The increase in service use provides initial evidence that state employee members are not experiencing access challenges.

Figure. Reduction in outpatient facility prices following introduction of the Oregon State Employee Plan Hospital Payment Cap, 2014-2021



To date, all 24 hospitals have remained in-network, and none have had to close. In line with a broader body of research, we found no evidence of "cost-shifting" during the first two years and three months of the cap—facility prices for non-state employee commercial enrollees at the 24 hospitals were not statistically different from prices at Oregon's non-exposed hospitals from October 2019 through

[14] Oregon State Legislature. 79th Oregon Legislative Assembly—2017 Regular Session, SB 1067 enrolled, Relating to government cost containment; and declaring an emergency, Chapter 746 [Internet]. Salem (OR): The Legislature; [cited 2024 Feb 12]. Available from: https://olis.oregonlegislature.gov/liz/2017R1/Measures/Overview/SB1067
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December 2021.[17, 18] Preliminary analysis of hospital responses to the cap also reveals limited evidence of changes in hospital finances, operations, or patient experience of care.[19]

Oregon's policy has proven successful in controlling hospital prices and generating savings for the state and enrollees, without harming patient access, care quality, or hospitals' ability to operate—at least in its early years. These findings suggest that similar policies could offer meaningful savings and improve health care affordability in other states, without risking significant unintended consequences for patients or hospitals.

Washington's proposed legislation to lower costs and increase care for public and school workers offers a similar opportunity to control hospital prices and spending. Washington's bill would set a cap at 200% of Medicare, as Oregon did, but would have a few key differences. First, it would apply to all of the state's hospitals with separate caps for critical access, sole community, and children's hospitals to help protect the financial stability of these more vulnerable facilities. Second, instead of a separate out-of-network cap, Washington's policy includes a participation requirement that ensures all hospitals that receive payment through any program administered by the Health Care Authority contract with the state's carrier, thereby shifting negotiating leverage to the state and maintaining patient access. Finally, Washington's policy would establish a payment floor for primary care and behavioral health services to ensure that these services remain accessible.

My research suggests that these differences are unlikely to significantly change the impact of Washington's policy compared to Oregon's. Instead, it is likely to similarly reduce spending without compromising care or restricting access for enrollees, while also likely improving access to primary care and behavioral health services. I hope this testimony provides helpful insights as you consider potential solutions to rising health care spending in Washington state.

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[18] Frakt AB. How much do hospitals cost shift? A review of the evidence. Milbank Quarterly. 2011; 89(1):90-130.
[19] Murray RC. The Effect of Oregon's Payment Cap on Hospital Finances, Operations and Patient Access and Experience. Paper presented at: American Society of Health Economists 13th Annual Conference; June 2024; San Diego, CA. Available from: https://ashecon.confex.com/ashecon/2024/meetingapp.cgi/Paper/15319