CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
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Hospital Payments Caps Impact on Prices and Spending

Lessons from the Oregon State Employee Plan

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Testimony of Roslyn C. Murray submitted to the Health and Human Services Committee of the Nevada State Assembly on hospital payment caps impact on prices and spending.

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[1] The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.
[2] The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chair Brown-May, Vice Chair Nguyen, and members of the committee, thank you for the opportunity to provide written testimony on the potential impact of hospital price caps. My name is Roslyn Murray and 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), where I focus on evaluating policies and programs designed to improve health care affordability in the United States, such as the policy contemplated in AB 349. The information I share today draws on various studies my colleagues and I have conducted evaluating hospital payment policies and my expertise in hospital payment reform.

Hospital Prices Threaten Health Care Affordability in the U.S.

Hospital prices are the main driver of rising health care spending in the United States.[3, 4, 5] Spending on hospital care amounted to $1.5 trillion in 2023.[6] In the commercial insurance market, hospitals leverage their market power to negotiate high prices. And this situation is worsened by consolidation.[7, 8] 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 break-even level for efficient hospitals.[9, 10, 11] Average inpatient facility prices rose from 110% of Medicare rates in the late 1990s to 254% of Medicare rates in 2022.[12] On average, inpatient facility prices in Nevada were

[3]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).
[4] 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).
[5] Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018; 319(10):1024–1039.
[6] Centers for Medicare and Medicaid Services. National health expenditures data: historical [Internet]. Baltimore (MD): CMS; 2024 Dec 18 [cited 2025 Jan 27]. Available from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet
[7] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? Hospital prices and health spending on the privately insured. O J Econ. 2019; 134(1):51-107.
[8] Gowrisankaran G, Nevo A, Town R. 2015. Mergers when prices are negotiated: Evidence from the hospital industry. American Economic Review 105(1): 172-203
[9] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2024 Mar. Chapter 3, Hospital inpatient and outpatient services; [cited 2025 Jan 28]. Available from: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch3_MedPAC_Report_To_Congress_SEC-1.pdf
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[11] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2020 Mar. Chapter 3, Hospital inpatient and outpatient services; [cited 2024 Mar 5]. Available from: https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/
[12] 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): 214750.

259% of Medicare rates in 2022, while outpatient facility prices were 322% of Medicare rates.[13] This growing cost burden is felt by individuals and families through higher premiums, increased out-of-pocket spending, stagnant wages, and job losses, especially for low-wage workers.[14, 15] Additionally, the ability of certain hospitals to command high prices has contributed to a divide between "haves" and "have-nots", where the former can build substantial reserves, while the latter struggle to maintain core operations.[16, 17]

Oregon's Payment Cap Saved the State Employee Plan Over $100 Million

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 enacted legislation in 2017 to cap hospital facility prices for care provided to employees of state agencies and universities, state educators, and their dependents, all of whom are covered under the state employee plan. The cap, which took effect in October 2019, prohibits the state employee plan's carriers from paying in-network hospitals more than 200% of Medicare rates for services provided to its members.[18] Services received at out-of-network hospitals cannot exceed 185% of Medicare rates, and patients cannot be charged more than their in-network cost-sharing amounts. Twenty-four of Oregon's large, urban hospitals are subject to this legislation. Critical access hospitals and other small and rural hospitals are exempt.

In evaluating the Oregon policy, my colleagues and I found that outpatient facility prices paid by the state employee plan 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).[19] 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.[20] The

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[13] Whaley CM, Kerber R, Wang, D, Kofner A, Briscombe B. Prices paid to hospitals by private health plans [Internet]. Santa Monica (CA): RAND Corporation; c 2024 [cited 2025 Jan 27]. Available from: https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

[14] 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.

[15] Brot-Goldberg Z, Cooper Z, Craig SV, Klarnet LR, Lurie I, Miller CL. Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers. National Bureau of Economic Research; 2024 Jun 24. Available from: https://www.nber.org/system/files/working_papers/w32613/w32613.pdf

[16] 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.

[17] 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.

[18] 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

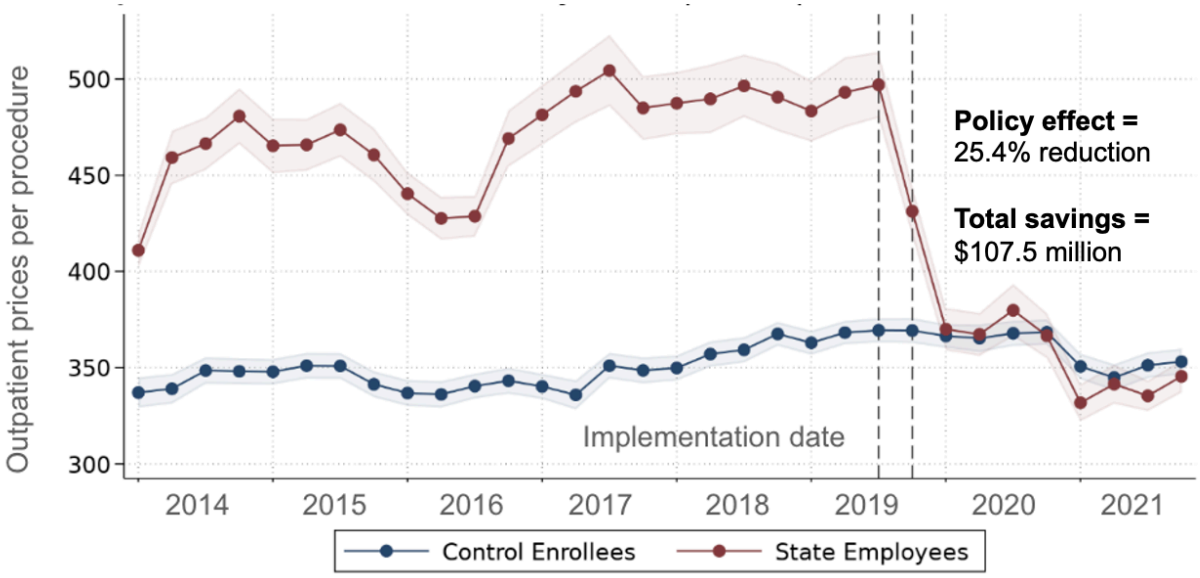
[19] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024; 43(3).

[20] Murray RC, Norton EC, Ryan AM. Oregon's hospital payment cap and enrollee out-of-pocket spending and service use. JAMA Health Forum. 2024;5(8):e242614. doi:10.1001/jamahealthforum.2024.2614

increase in service use provides initial evidence that state employee members are not experiencing access challenges.

To date, all 24 hospitals have remained in the state employee plan's network, and none have had to close. The lower out-of-network rate cap may have played a role in encouraging hospitals to remain in-network with the state employee plan. In line with a broader body of research, we found no evidence of "cost-shifting" to commercial plans 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 December 2021.[21, 22] Preliminary analysis examining hospital responses to the cap suggests that it had no negative impacts on hospital finances, operations, or patient experience of care.[23]

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



Oregon's policy has proven successful in controlling hospital prices and generating savings for the state and its members, 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.

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[21] 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).
[22] Frakt AB. How much do hospitals cost shift? A review of the evidence. Milbank Quarterly. 2011; 89(1):90-130.
[23] 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

Nevada's Proposed Bill Has the Potential to Lower Hospital Prices Without Harming Patients and with Limited Impacts on Hospitals

Nevada's proposed legislation aims to lower costs for the public employees' benefits program, while also allowing local governments the option to do the same. Similar to Oregon's approach, the bill would establish in-network and out-of-network payment caps for care provided to state employees at large, urban hospitals, with a few minor differences. Specifically, the bill proposes caps at 175% of Medicare rates for in-network services and 160% for out-of-network services. The legislation would also allow other public employee plans to opt into these caps, including plans from local governments, higher education institutions, and school districts.

The public employees' benefits program constitutes about 3% of hospitals' commercial revenue share in Nevada. Based on data from the Hospital Price Transparency Study and the National Academy for State Health Policy Hospital Cost Tool, I estimate that the policy would generate $36 million in annual savings for the public employees' benefits program. Savings would be greater if other public employee plans opt in. In 2022, large, urban Nevada hospitals generated $3.3 billion in commercial revenue from patient care, with aggregate commercial operating margins of 38.0%.[24] The anticipated revenue reduction, if applied solely to the public employees' benefits program, would represent 1.1% of these hospitals' total commercial revenue and result in a 0.7 percentage point reduction in their commercial margins to 37.3%. These differences are unlikely to significantly affect hospitals' ability to operate, patient access, or care quality.

Conclusion

States are increasingly seeking opportunities to improve health care affordability in the face of rising hospital prices and spending. My research demonstrates that Oregon's hospital payment cap for state employees offers a promising model, successfully reducing hospital prices and spending with minimal disruption to hospitals and patients. Nevada's proposed bill could present an opportunity to achieve similar goals of improving health care affordability.

[24] National Academy for State Health Policy. NASHP Hospital Cost Tool [Internet]. NASHP; 2025 Feb 7 [cited 2025 Feb 21]. Available from: https://tool.nashp.org/