Office of Affordable Health Care

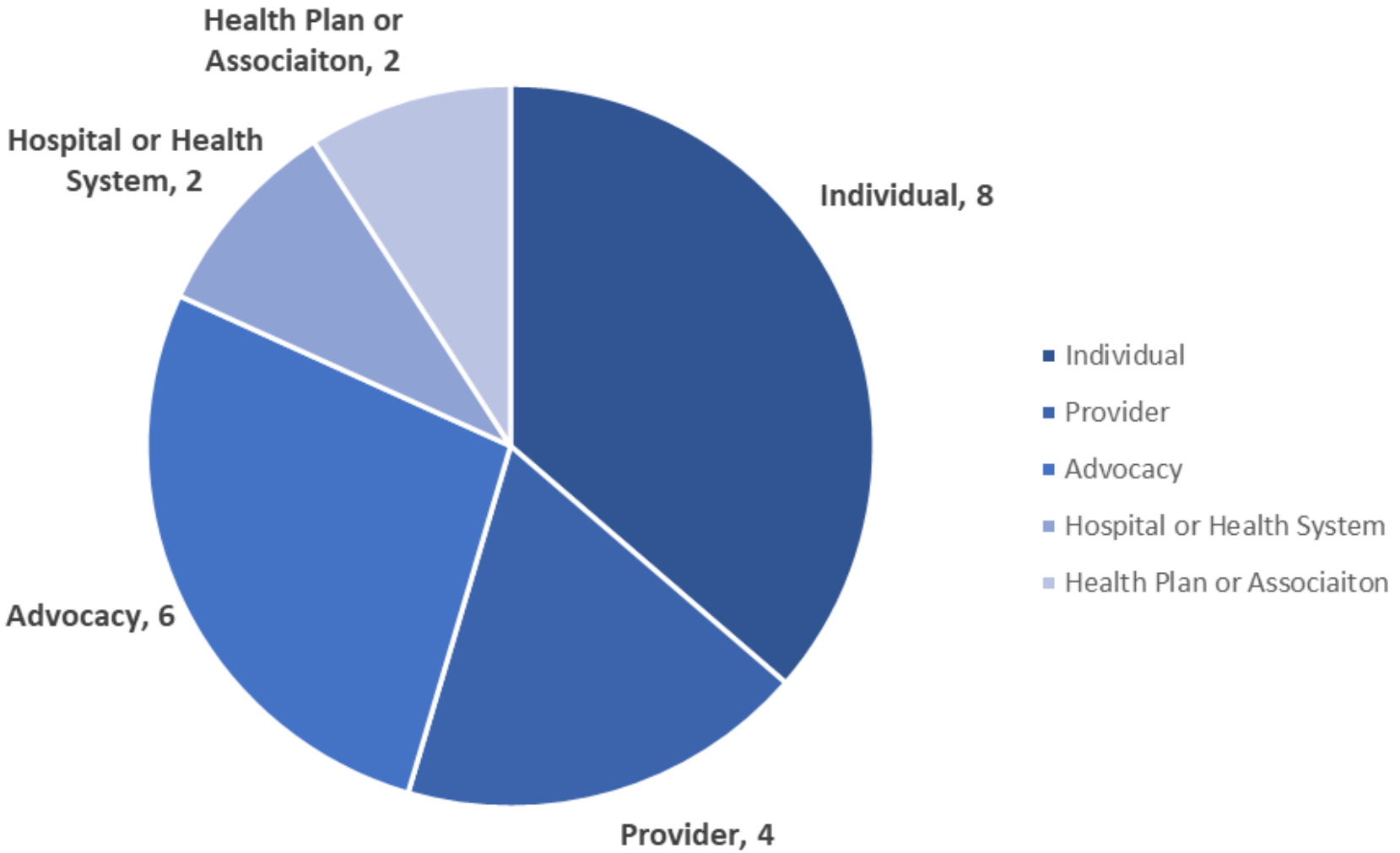
Advisory Council Meeting, November 5th, 2025

Agenda

- Annual Public Hearing Comment Summary
- Update on Development of Policy Concept on Provider Price Regulation

Annual Public Hearing Comment Summary

Participation Overview



General Themes in Comments

- **Barriers to health care access and affordability:**
  - Federal level Medicaid cuts and expiration of EPTCs
  - General lack of affordability
  - Lack of access to primary and behavioral health care
  - High hospital prices and consolidated market power
  - Hospital payment plans
  - Lack of anti-competitive contract terms
  - High labor costs
  - Prior authorization and administrative burdens
  - Coverage mandates

Themes – Consumers, Independent Providers, Advocacy Groups

Category	Themes
Consumers	• Expiration of EPTCs and rising premiums • Coverage denials • Unaffordable hospital payment plans • Forgoing treatment due to concerns about cost
Independent Providers	• Federal cuts to Medicaid and expiration of EPTCs • Patients skipping or delaying care due to cost • Access to primary and behavioral health care
Advocacy Groups	• Prevalence of medical debt • Federal cuts to Medicaid and expiration of EPTCs • Lack of universal health care system • High hospital prices • Anti-compeititve behavior in a consolidated market

Themes – Insurers & Hospitals/Health Systems

Category	Themes
Insurers	• Provider market consolidation and anti-competitive behavior • High hospital prices • Limits on utilization management/prior authorization • Mandated coverage benefits

Hospitals/Health Systems	• Federal level Medicaid cuts
	• Labor costs
	
	• Other touchpoints:
	  • Administrative burdens (such as prior authorization)
	  • Broken continuum of care
	  • Need for consideration of quality, access, and cost (Triple Aim approach)

Update on Policy Development

Regulation of Hospital Prices in Other States

Recognizing the role that prices paid for health care services contribute to both household health spending and system-wide spending, states are increasingly implementing programs to exert direct or indirect downward pressure on provider prices, such as:

- **Hospital price growth caps**
- **Reference-based pricing in state employee programs**
- **Price caps in public option plans**

Price Growth Caps

A price growth cap limits how much provider payments can grow each year; the cap can be linked to an economic indicator such as Consumer Price Index (CPI), gross state product (GSP) growth, or to Medicare growth indices.

- Measured at the service level or an aggregate level.
- Applied to all hospitals, or to certain classes of hospitals where price growth has been problematic.
- Could vary based on relative baseline prices.

State examples: Rhode Island and Delaware

Price Growth Caps State Example: Rhode Island

Since 2010, Rhode Island has utilized "Affordability Standards" in insurance rate review, which includes a limit on the average annual payment increases for hospital inpatient and outpatient services in insurer contracts.

- The current price growth cap is the Consumer Price Index (CPI) + 1%.

The State enforces the price growth cap through the rate review process and market conduct examinations. While this technically limits enforcement to the state-regulated insurance market, Rhode Island insurers generally negotiate rates across product lines, so regulators believe the growth caps have also had some more limited impact on costs in the self-insured employer market.

Evidence of Success from Rhode Island

A 2025 study published in Health Affairs found that the Affordability Standards resulted in an average of **$87.7M in *annual* savings**

- $64M of this accrued to employers, while $23.7M accrued to consumers in the form of premium and out-of-pocket cost savings.
- By 2022, the authors found that hospital price reductions translated into annual savings of $1,000 per member in fully-insured plans.

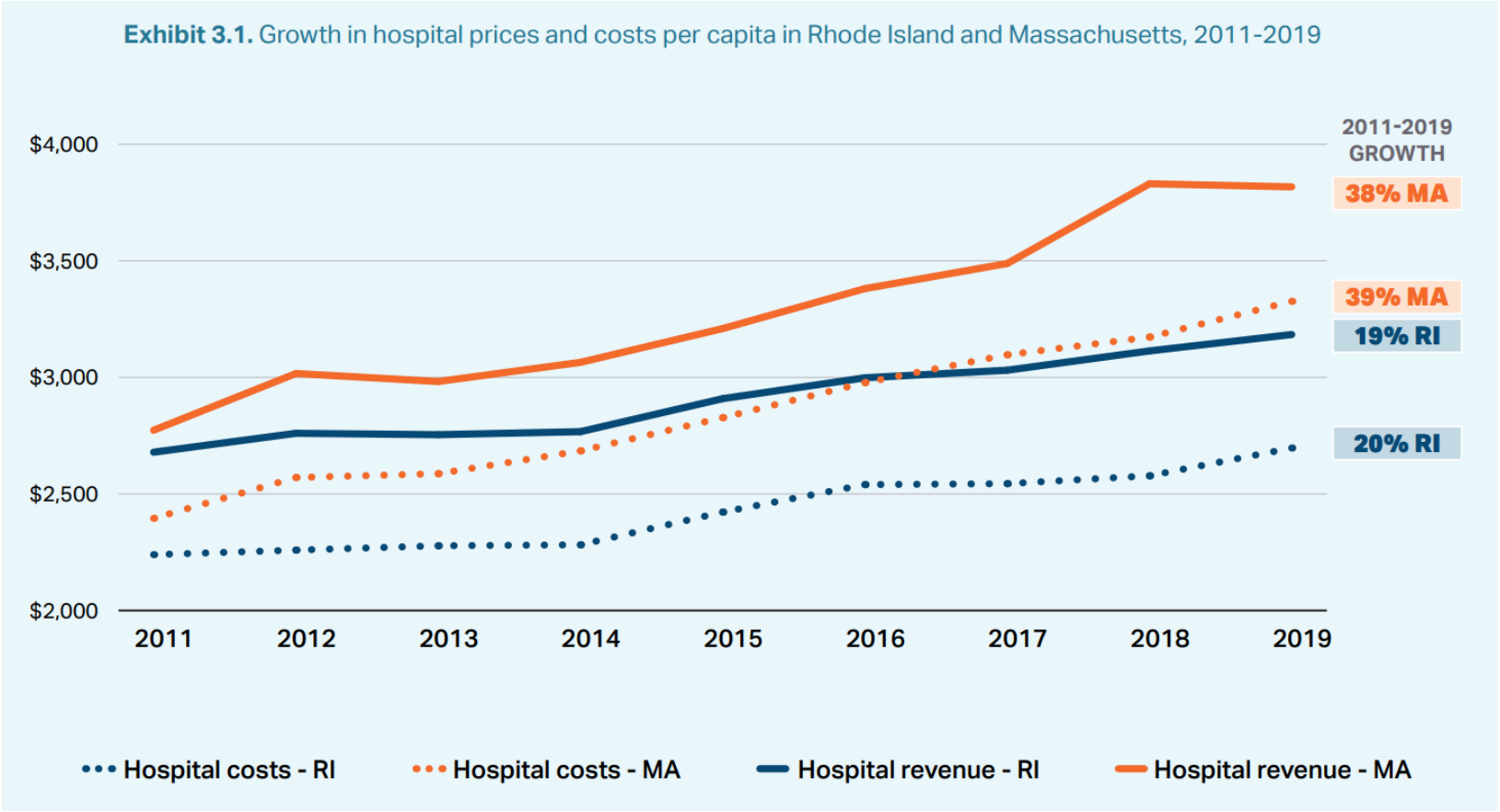
An earlier evaluation found that the Affordability Standards were associated with a 5.8% decrease in total per capita health care spending among the commercially insured population.

Sources: Ryan AM, Whaley CM, Fuse Brown EC, Radhakrishnan N, and Murray RC. Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums. *Health Affairs* 2025 44:5, 597-605. Baum A, Song Z, Landon BE, Phillips RS, Bitton A, and Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. 2019;38(2):237–45

Evidence of Success from Rhode Island

While hospital revenue and costs in Massachusetts and Rhode Island were similar in 2011, revenue grew significantly more slowly in RI following the implementation of the hospital price growth cap.

Importantly, as growth of prices was limited in Rhode Island, growth of patient care costs also slowed.



Source: Massachusetts Health Policy Commission, *2023 Annual Health Care Cost Trends Report and Policy Recommendations*, September 2023.

Reference-based Pricing in State Employee Health Plans

Under reference-based pricing strategies, hospital payments are capped at a certain level, typically at a percentage of Medicare rates, for both inpatient and outpatient facility services. Price caps can be implemented on a service level, or at an aggregate level.

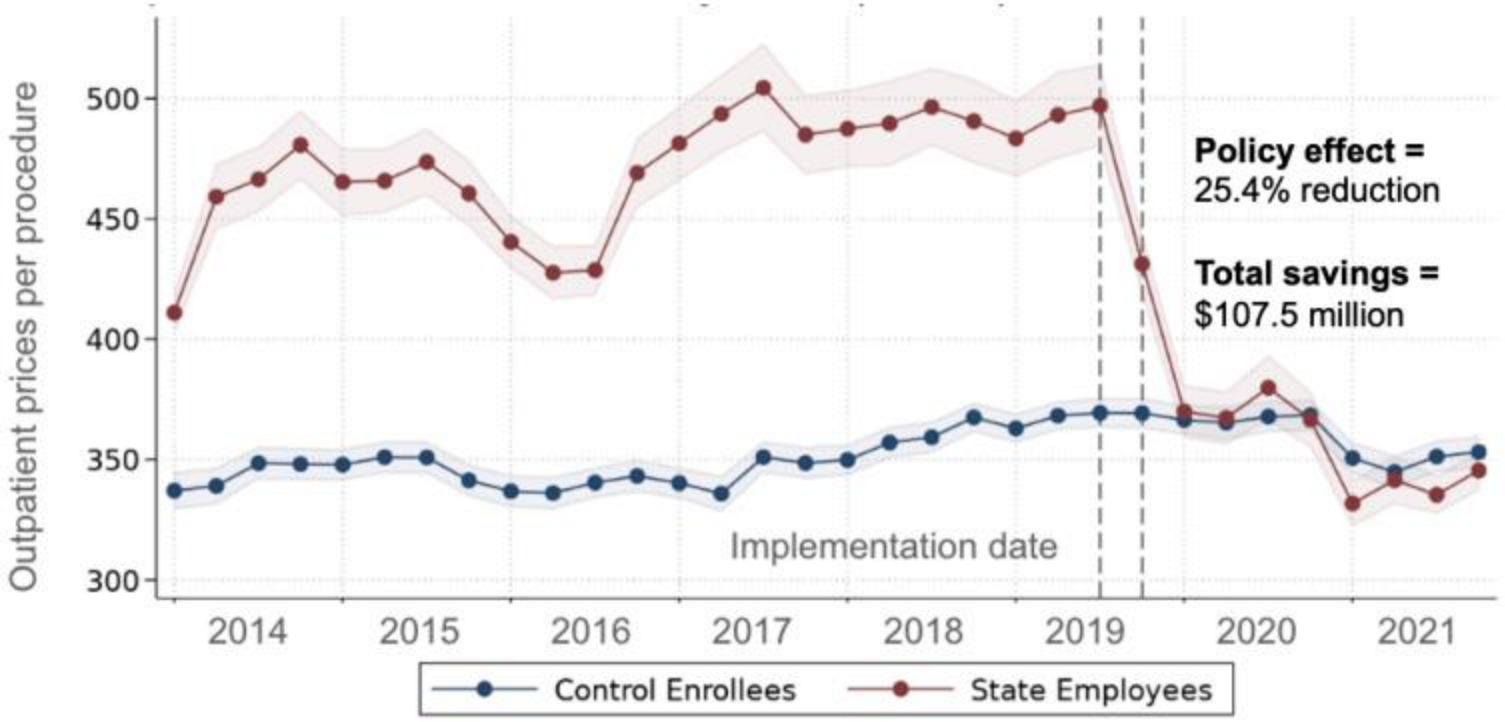
State Examples

- Oregon's SEHP pays no more than 200% of Medicare prices for in-network hospital services, and 185% of Medicare prices for out-of-network services. Some small and/or rural hospitals were exempted from the program.
- Washington recently passed legislation limiting how much Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans pay for hospital inpatient and outpatient services to no more than 200% of the Medicare rate. The law also sets minimum payment levels for primary care and behavioral health services to at least 150% of Medicare.

Evidence of Success in Oregon

A 2024 evaluation found that the price caps generated over **$100 million in savings** over the first 27 months of implementation, driven mostly by reduced outpatient prices.

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



Source: Roslyn C. Murray, *Hospital Payments Caps Impact on Prices and Spending Lessons from the Oregon State Employee Plan*, Testimony Submitted to the House Appropriations Committee of the Washington State Legislature, January 28, 2025.

Evidence of Success in Oregon

The same evaluation found that there were no negative impacts on:

- Access to care for employees – none of the 24 hospitals participating in the plan exited its network
- Hospital finances, operations, or patient experience of care
- Cost-shifting to other commercial insurers

The Oregon state employee health plan covers roughly 13% of the commercially covered population in Oregon.

Source: Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital Facility Prices Declined as a Result of Oregon's Hospital Payment Cap. Health Affairs. 2024;43(3):424–32.

Considerations for Policy Development

- Ability to implement policy without reliance on federal government collaboration
- Reach of the policy to the maximum number of people possible
- Prioritizing cost relief for consumers
- Balancing cost relief with investments to improve access

Recommended Policy Framework

Set Reasonable Limits on Commercial Hospital Facility Prices

- Cap outlier high prices for hospital services
- Establish a cap on the growth of hospital prices

Use Savings To:

Reduce health care costs for families and businesses

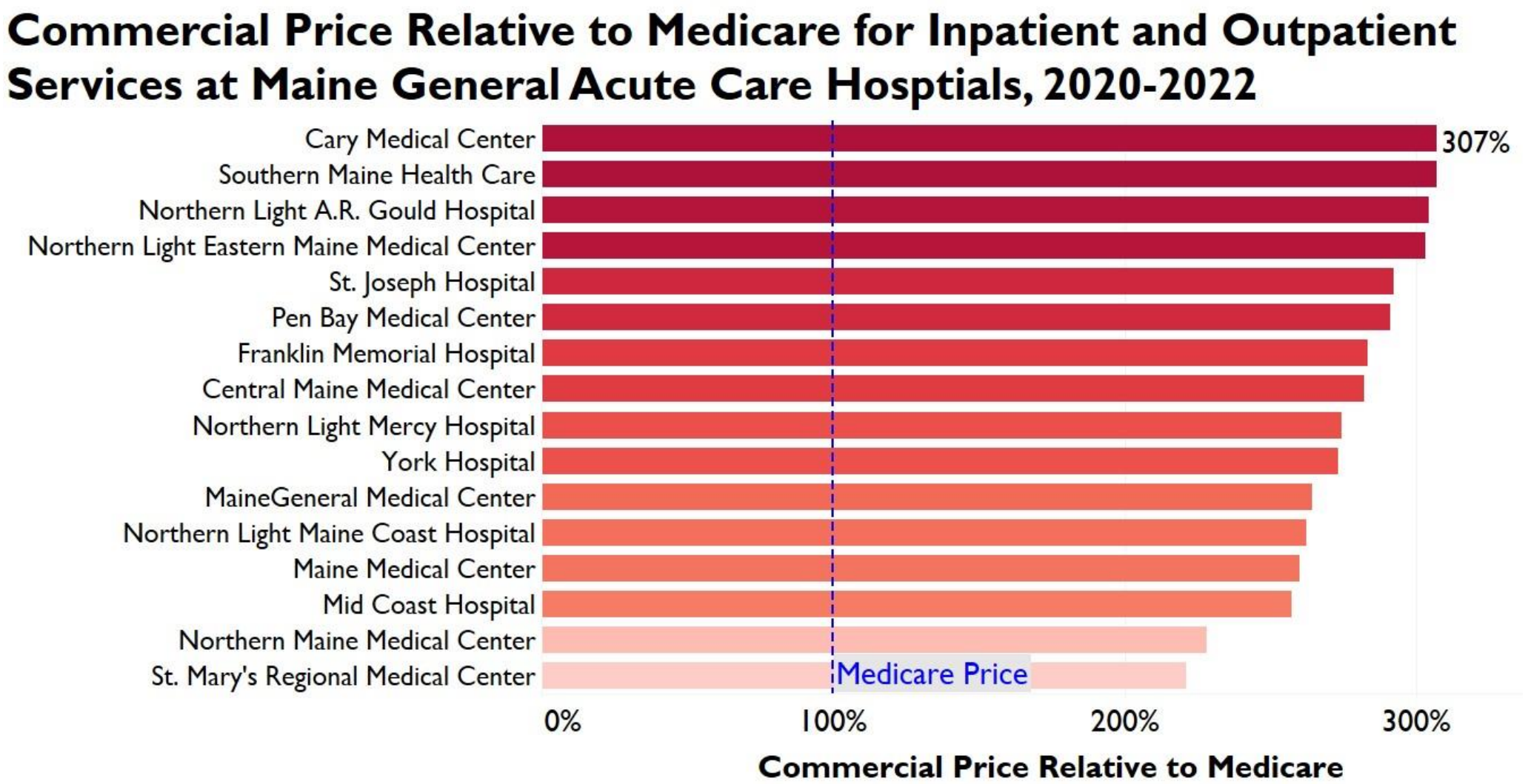
Invest in higher payments for primary and behavioral health care

Reform prior authorization to lessen admin burden on providers

Price and Price Growth Caps – Next Steps

- Establishing the basis of a benchmark
  - Recommend using Medicare prices as a benchmark. Information is relatively transparent, accessible, and predictable.
- Establishing benchmark levels
  - Considering current payment rates, what is a reasonable cap on prices as a percent of the benchmark
- Considering the scope of the caps, and exemptions
  - Other states have generally included exemptions for small and rural hospitals.
  - Maine could also include an exemption for financial performance, in light of stability concerns.

Most Maine hospitals charge commercial payors more than 2.5 times Medicare prices



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

ROUGH Estimate of Savings from Price and Growth Cap Policies

	Year 1	Year 2	Year 3*	Year 4	Year 5	Total 10 Years
250% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	$532M	$574M	$618M	$5.6B
Price Growth Cap	$56M	$117M	$183M	$255M	$333M	$4.0B
250% TOTAL	$56M	$117M	$715M	$829M	$951M	$9.6B
225% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	$763M	$810M	$860M	$7.6B
Price Growth Cap	$56M	$117M	$183M	$255M	$333M	$4.0B
225% TOTAL	$56M	$117M	$946M	$1.1B	$1.2B	$11.6B
200% Medicare Benchmark						
Service Level Price Cap*	N/A	N/A	$994M	$1.05B	$1.1B	$9.6B
Price Growth Cap	$56M	$117M	$183M	$255M	$333M	$4.0B
200% TOTAL	$56M	$117M	$1.2B	$1.3B	$1.4B	$13.6B

* Phased in price caps begin year 3

Source: Bailit Health (2025). Analysis of RAND 5.1 Hospital Transparency Data; Maine Health Data Organization. (2025). Hospital Financial Reporting

Increasing Investment in Primary Care and Behavioral Health Care – Next Steps

- Primary care and behavioral health care have been repeatedly cited as areas where providers feel that reimbursement is insufficient
  - Access challenges, especially long wait times for appointments, are also a theme across consumer input we receive
- Establish primary care and behavioral health care be defined
  - Could use Evaluation and Management codes provided by certain provider types
- Establishing benchmark levels
  - Like caps, consider current price levels
  - Weigh the prioritization of increased investment with delivering savings to consumers

ROUGH Estimate of Reinvestment

Primary care and behavioral health professional services for E&M codes at 110%

	Year 1	Year 2	Year 3*	Year 4	Year 5	Total 10 Years
250% Medicare Benchmark						
Reinvestment Costs	$38M	$38M	$38M	$38M	$38M	$339M
Policy Savings*	$56M	$117M	$715M	$829M	$951M	$9.6B
Premium Pass Through	$18M	$79M	$677	$791	$913	$9.2B
225% Medicare Benchmark						
Reinvestment Costs	$38M	$38M	$38M	$38M	$38M	$339M
Policy Savings*	$56M	$117M	$946M	$1.1B	$1.2B	$11.6B
Premium Pass Through	$18M	$79M	$908M	$1.0B	$1.2B	$11.3B
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* Phased in price caps begin year 3

Source: Bailit Health (2025). Analysis of RAND 5.1 Hospital Transparency Data; Maine Health Data Organization. (2025). Hospital Financial Reporting; Health Care Cost Institute (2024). Health Care Prices tool at www.healthprices.org

Incorporating Changes to Prior Authorization

- Starting point could be requiring carriers to comply with existing limitations on prior authorization which currently apply to the fully-insured market. These include:
  - A request by a provider for PA must be answered by a carrier within 72 hours or 2 business days, whichever is less
  - Prohibition on retrospective denials coverage or payment for the originally approved service (with exception for fraud or materially incorrect information)
  - Requirement that appeals be reviewed by a clinical peer who was not involved in the initial decision

- Also soliciting input from Advisory Council members and others about changes that could reduce the use of prior authorization in the case of services that are generally approved, or other changes.