Advisory Council on Affordable Health Care

March 4th, 2026

LD 2196

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 in upstream services that are currently undercompensated by some commercial insurers

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

Rebalance spending to better support primary and behavioral health care

Reduce administrative burden through changes to prior authorization

Part A: Hospital Price Caps and Price Growth Caps

- **Price Caps:** Limits the maximum amount that a general acute care hospital may charge or collect from a commercial insurer, employer, or individual for any inpatient or outpatient facility service to no more than 200% of Medicare beginning January 1, 2028
  - Critical Access Hospitals are exempt
  - Hospitals determined to be financially distressed are exempt – the Office is charged with developing a methodology to define and apply financial distress using audited financial data collected by MHDO.
- **Growth Caps:** Beginning January 1, 2028 and annually thereafter, limits annual growth of hospital prices to a percentage equal to the inpatient prospective payment system hospital market basket adjustment, which is the metric used to determine annual increases in Medicare payments. This metric was selected because it is specifically designed to account for increases in hospital operating costs (as opposed to a more general measure of inflation, like CPI).

Discussion – Part A

- If not 200% of Medicare, at what level should prices be capped?
- Any feedback on exemptions from the policy?
  - Advice on specific metrics and benchmarks to identify hospitals at risk of closure due to financial performance?
- Any feedback on the use of Medicare IPPS Market Basket as opposed to other metrics of inflation such as CPI?

Part B: Changes to Prior Authorization to Reduce Administrative Burden

- Initial prior authorization for the treatment of a chronic condition and for related diagnostic procedures or tests must remain valid for one year and renewal may not be required more frequently than once every two years, unless there is a new treatment protocol introduced
- A carrier may not restrict coverage for a health care service or prescription that was approved under a previous health plan within 90 days of an enrollee's enrollment in the new health plan
- Additionally, self-insured plans not subject to state regulation of insurance must also comply with other restrictions on prior authorization which apply to fully-insured plans, or hospitals are not required to comply with price caps in their contracts:
  - 72 hour/2 business day turnaround for decisions in non-emergency cases
  - Prohibition on retrospective denials
  - Appeals conducted by clinical peer

Discussion – Part B

- Are there any additional provisions that would be meaningful in this section?
- Estimating the exact claim cost of these provisions is difficult given limited data and research – do members have advice on scoping cost?

Part C: Increasing Investment in Primary Care and Behavioral Health Care; Rate Review

- Requires that the minimum negotiated charge of a carrier for in-network primary care or behavioral health care services may not be less than 110% of the relevant Medicare rate
  - This would apply to a core set of evaluation and management and counseling services which represent the majority of revenue for most primary care practices, and a significant portion of revenue for behavioral health providers.
- This section also includes language that requires health insurance carriers to provide granular price data to the Bureau of Insurance when they submit their annual rate requests, to equip the Bureau to ensure that consumers benefit from lower prices required in the bill.

Discussion – Part C

- If not 110% of Medicare, at what level should payment floors be set?
- We have received some feedback with concerns about health insurance carriers lowering rates to the floor, rather than treating it as a minimum. Do Advisory Council members share this concern? Or have thoughts about how it could be addressed?