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Report on Useful Rate Setting Methods and Techniques from the
Maryland Hospital All-Payer Rate Setting System

Part 2: State Roadmap for Development of Advanced Hospital Rate Setting Systems & Complementary Programs

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Part 2: State Road Map for the Development of Rate Setting Strategies for the Private Sector and Complementary Programs

I. Introduction & Overview

A. Introduction

This section contains descriptions of potential rate-setting strategies and key rate-setting methods and programs that states might wish to develop to assist in the control of hospital price and spending growth. We begin by describing a potential “Road Map” for state regulatory action. As noted in Part 1, we would normally recommend that states aggressively pursue the approval of a Medicare Waiver from CMS and CMMI, which would allow a state to develop statutory rate-setting authority over hospital rates paid by all payers, including Medicare, Medicaid and privately insured/self-funded ERISA plans. Literature evaluating the effectiveness of past state-based rate setting systems showed that all-payer rate setting systems, were most effective in controlling hospital price and spending growth and achieving other health policy goals.

However, given the present federal administration’s lack of support for rate setting generally and the approval of Medicare Waivers in particular, it is highly unlikely that a state would receive approval for a Medicare Waiver currently. Accordingly, we emphasize the need for states to focus on the incremental development of state legislation to implement various rate regulatory programs for regulating hospital rates paid by private sector payers.

As we will discuss in more detail, our recommended strategy would first involve the implementation of Reference Based Price (RBP) Caps on hospital payments from a State Employee Health Benefit Program (SEHBP). For most states, these benefit programs also apply to public employees, including employees of counties, cities and other municipalities. Once a state has gained needed experience with RBP Caps, it might next consider promoting legislation to apply RBP Caps to all Out-of-Network (OON) hospital payments by private insurers. Evidence from the Medicare Advantage (MA) market, which applies price caps to OON services for MA plans, indicates that OON price caps can enhance insurer negotiating leverage relative to hospitals and result in lower overall hospital prices and spending by private insurers. RBP Caps on

all OON prices paid by private insurers can also help address weaknesses in the current federal No Surprises Act, which has failed to protect patients from surprise billing because of a cumbersome and ineffective Independent Dispute Resolution (IDR) process.

Next, after gaining experience with RBP Caps, states might opt for the strategy currently being pursued by Vermont, which is to apply RBP Caps to all private sector hospital payments. Given the success of Oregon's use of RBP Caps for its state and public health benefit programs, RBP Cap can both truncate extremely high hospital prices and effectively moderate the growth in private insurer spending on hospital care, helping to improve the affordability of private insurance.

RBP Caps can be effective price and spending constraint tools, the establishment of RBP Caps, benchmarked to a multiple of Medicare prices, can also enable a state to develop a more equitable and economically rational hospital pricing system for private insurers. This is because Medicare prices were established to reflect the relative costliness of different hospital services. A more rational pricing system, linked to Medicare relative prices, could provide the basis for a state to transition to a system of more rational and equitable regulated base (i.e., initial) hospital unit rates (i.e., actual regulated payments levels for each service). By setting RBP caps linked to a multiple of Medicare prices, as was accomplished in Oregon and is being actively pursued in Washington and Vermont, a state might gradually transition these price caps to a series of actual base rates, regulated by a state's regulatory authority. Unlike RPB Caps, these base rates would set both a ceiling and floor on payment for a given hospital service (i.e., a rate per hospital admission, a rate per ER visit or a rate per diagnostic test). Past state-based rate setting systems, such as Maryland, Massachusetts, New Jersey and New York took many years to develop data-intensive methodologies to establish a rational and equitable set of base rates over several years. In this section, we will outline a potential approach for a state to transition from a system of RBP Caps to a system of more equitable and rational regulated base unit rates paid by private insurers.

With the establishment of base regulated unit rates for each hospital service, applicable to private insurer payments, the state will have additional flexibility to incorporate other adjustments and beneficial rate setting mechanisms. These additional and complementary programs and methods include: 1) the use of a Volume Adjustment System (VAS) to correct the flawed incentives of Fee-for-Service (FFS) payment that induces hospitals to over-produce services and penalizes hospitals financially when volumes decline; 2) a mechanism to fund hospital Uncompensated Care (UC) through a system of surcharges on regulated hospital rates and the potential use of UC funding pools to spread the burden of funding UC more equitably; and 3) a system of supplemental financial incentives to promote improved hospital quality of care, including

reduced readmission rates, hospital acquired conditions, infection rates and other negative health outcomes. As we will discuss, these latter two valuable rate setting programs should, however, only be implemented when a state has secured approval of a Medicare Waiver and begun to implement an all-payer rate setting system.

II. Proposed Rate Setting Roadmap For States

A. Introduction

It is widely recognized that states are currently struggling with uncontrolled increases in hospital prices and spending in private insurance markets. It now appears that none of the interventions proposed to control or reduce healthcare spending, such as improved price transparency, more aggressive antitrust activity, the implementation of largely voluntary Value-Based Payment (VBP) initiatives, or more aggressive negotiating tactics by private insurers, have had any significant impact improving the competitiveness of hospital markets or otherwise constraining the continued growth in hospital prices and spending.

Given the aversion of the federal administration and current Congress to the use of government regulation in healthcare markets to address excessive hospital price and spending growth in the U.S., it seems that states must now take the lead in proposing and developing government-administered rate control programs to improve the affordability of healthcare and achieve other policy goals. The diminished prospects that CMS and the CMMI will approve All-Payer Waivers, which would allow a state to set rates for both public and private payers, means that states must first focus rate setting activity on the rates paid for public employees and by private insurers and self-funded ERISA plans.

The following section proposes a potential “Roadmap” for states in their quest to improve the overall functioning of healthcare markets and the affordability of healthcare services (particularly hospital services) in their states.

B. Step 1: Reference Based Price (RBP) Caps for State/Public Employees Programs

As is the case for all private sector insurance programs, state and public employee health benefit programs nationally are struggling to fund the hospital expenditures for their employees and other beneficiaries, defaulting to large increases in annual premiums and cost sharing requirements. These programs, which for many states can represent the largest purchasers of

private health insurance, are consuming an ever-larger portion of state budgets because of efforts to fund rising insurance premiums for these programs. As researchers at Brown University observed, “states are under growing budgetary pressure due to rising health care spending primarily through increases in hospital and drug prices.”¹ Several states’ experience with growing funding needs provides examples of what many states are experiencing nationwide.

New Jersey’s experience in this regard is the most extensively documented example of a state/public employee health plan in financial distress, driven primarily by escalating hospital prices. The State’s actuary recommended double-digit premium increases for all three state-administered plans for plan year 2026: a 36.5% increase for the local government plan, 29.7% for the School Employees’ Health Benefits Program, and 21% for the State Health Benefits Program. (SHBP) All three plans experienced deficits in both 2024 and 2025. The SHBP lost \$154 million in 2024 and \$232 million in 2025; the local government plan lost \$75 million and \$57 million; and the school employees’ plan showed overruns of \$143 million in 2024 and \$254 million in 2025. Over the prior five years, premiums for the local government plan rose 115%, the school employees’ plan saw a 73.9% increase, and the state plan rose 67.3%.^{2,3}

North Carolina’s State Health Plan is projected to experience a \$500 million shortfall in 2026 and a \$800 million shortfall in 2027, driven by rising hospital and drug prices.⁴ A Mercer survey found that 2026 will be the fourth consecutive year of higher health benefit cost growth following much lower annual increases, averaging only about 3%. The survey found that 59% of employers will make cost-cutting changes to their plans in 2026, up from 48% in 2025 and 44% in 2024. These changes largely involve raising deductibles and other cost-sharing provisions, which can lead to higher out-of-pocket costs for plan members when they seek care.⁵

Illinois, a state with high per capita income, has also experienced significant increases in spending on employee health programs. The state’s employee health benefit system projected spending increases of approximately 10.5% in fiscal year 2026 over fiscal year 2025, while spending in 2025 was about 15% higher than in the previous fiscal year. The average spending per beneficiary in the state is expected to grow 8.3% to \$12,051, and state general revenue contributions to the plan are expected to rise 12.8% to \$2.8 billion.⁶

Using data from 46 states and the District of Columbia the Brown University team estimated that payment caps for hospital care, set at 200% of Medicare rates would have saved state employee plans an average of \$150 million per state and aggregate savings of \$7.1 billion nationally as of 2022. This estimate was in part based on actual savings generated in the state of Oregon, which implemented such Reference Based Price (RBP) Caps for their State and Public employee benefit programs in 2019 and 2020 respectively. States generally face a requirement

in their state constitutions that require them to balance their annual budgets. States can use this requirement, as both Oregon and Washington did, along with the growing need to cap beneficiary premium and cost sharing increases, as a strong rationale to pursue RBP Caps and other forms of hospital rate regulation.

1. Reference Based Price Caps: Design Issues

There is a consensus among health researchers and policymakers that the prices set by Medicare for its Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) constitute the most sophisticated, extensively researched, and publicly transparent hospital payment system in the U.S. Medicare price levels also have the distinct advantage that they are set based on the relative cost levels of different hospital services. The adoption of prices that reflect relative costs will result in more efficient allocation of resources and more economically optimal outcomes. (i.e., economic theory teaches us that prices that reflect cost create incentives for producers to allocate their resources more efficiently and produce quantities of services that are demanded in the marketplace). This more efficient economic outcome stands in contrast to this country's current set of private sector prices, which have been distorted by decades of hospital and payer negotiations with prices that vary based on each hospital's relative negotiating market power. This has resulted in some prices being excessively high or low, relative to the cost of producing a service, and a misallocation of resources from under- (and artificially) valued hospital services to those services that reflect higher prices due to the negotiating leverage of most hospitals.

Another advantage to using Medicare prices as a benchmark for RBP Caps is they embody a number of adjustments that account for legitimate cost differences between hospitals. Medicare hospital payment levels contain adjustments to account for the following key (and legitimate) hospital cost characteristics.

1. **Hospital-specific cost factors:** Wage index adjustments reflecting local labor market differences, which typically represent the largest component of hospital costs
2. **Teaching mission recognition:** Indirect Medical Education (IME) add-ons compensating academic medical centers for the genuine indirect cost burden of residency training
3. **Safety-net mission support:** Disproportionate Share Hospital (DSH) payments and Uncompensated Care (UC) adjustments recognizing the cost of serving low-income and uninsured patients
4. **Geographic isolation:** Sole Community Hospital (SCH) and Medicare-Dependent Hospital (MDH) designations providing premium payments to isolated rural hospitals that serve as the only access point in their region

- 5. Outlier Payments:** Medicare's IPPS includes outlier payments for unusually costly cases. Failure to include an outlier mechanism in RBP programs could create incentives for hospitals to avoid high-acuity or complex patients or could expose plans to unanticipated costs if hospitals seek to renegotiate outlier-equivalent payments outside the cap framework.
- 6. Case complexity:** Diagnosis-Related Group (DRG) weights under IPPS and Ambulatory Payment Classifications (APCs) under OPPS provide extensive risk-adjustment for clinical complexity and resource intensity

The incorporation of some or all of these adjustments can create an effective and more equitable RBP Cap program because it is essential to ensure that the benchmark already accounts for legitimate cost differences across hospitals. A 200% cap on a hospital's full Medicare rate (which already includes its wage index, DSH, IME, and other adjustments) is far more equitable than 200% of a uniform base rate. Vermont's Brown University analysis notes that other states including Oregon and Washington have adopted Medicare-based price caps that benchmark commercial payments to what Medicare would have paid for the same service, including the Medicare's core unadjusted payment level and all applicable add-ons and adjustments.⁷

We would recommend that states benchmarking their rates or price caps to Medicare, also include the above-mentioned core adjustments to Medicare rates in order to develop the most equitable and fair rate setting or price cap system for hospitals. This is because these adjustments handle costs and other factors that are largely beyond the control of hospitals and thus should be used as an adjustment to rates. If states make use of the six core Medicare adjustments listed above, they can probably ignore other more "categorical" designations and associated rate enhancements that per current Medicare payment policy, such as rate enhancements for "Medicare-dependent" and "sole-community" hospitals. The states that have implemented or are planning to implement RBP Caps, make use of these core adjustments but ignore the use of the categorical designations listed above.

2. Oregon's and Washington's RBP Cap Programs

In 2019 the state of Oregon passed legislation to implement RBP caps on hospital payments, linked to 200% of Medicare IPPS and OPPS price levels as a means of controlling the growth in hospital spending financed by the State and Public employee benefit programs.⁸ This strategy has significant potential to kick-start rate regulatory activities in the state and has been organized in such a way so as not to generate overwhelming opposition by the hospital industry. The Oregon strategy is likely to be a clever and generally successful cost containment effort

because: a) the State/Public Employee benefit programs are large enough, covering about 15% of the private market, for the cost containment effort to generate significant state savings, but not so large as to incite hospitals to a full-scale political rebellion; and b) linking passage of the RBP Cap bill to passage of the state budget generated strong financial and political reasons for the state legislature to support and ultimately pass the legislation.

The Oregon price cap program also includes necessary provisions such as that hospitals should receive the “lower of” the RBP Cap or the current negotiated rate. Without this provision, hospitals currently paid at levels below the RBP Cap, could pressure Third Party Administrators to increase payment levels (a result which occurred before the state included this “lower of” provision). As was the case in Oregon, states should also prohibit any balance billing of beneficiaries to protect employees from hospitals attempting to extract higher payments directly from individuals. The Oregon legislation also included a provision to pay a lower rate, 185% of Medicare instead of the 200% of Medicare for in-network care, to encourage hospitals to remain in-network. To date, no Oregon hospital subject to this legislation has exited the Oregon State Health Employee Benefit Program (SHEBP) network.

Recently, the Oregon initiative was found to effectively control spending on hospital care, generating needed savings for the State, without creating significant negative impacts on hospitals.⁹ The program saved the state approximately \$50 million per year since implementation, without resulting in any detected reduction in hospital quality, diminished access to hospital care for state beneficiaries, or significant reductions in hospital revenues. There was some evidence that state/public beneficiaries in the program did increase the amount of hospital services they consumed, which was perhaps a predictable result given that beneficiaries experienced reduced cost-sharing obligations after the program was implemented.¹⁰

During the 2025 legislative session Washington passed similar price cap legislation to help the Washington’s public and state employee benefit programs to control the growth in hospital payments and reduce those programs’ spending on hospital care, in order to maintain or improve the affordability of insurance coverage for these employees.¹¹ The Washington legislation empowered the state’s public and state employee benefit programs to set RBP Caps on hospital prices.

3. Why RBP is an Ideal First Step

The legislative strategies of both states, represent an ideal first step to begin these states’ future healthcare price and spending control strategies for the following reasons:

1. Both the Oregon and Washington legislation were tied to the passage of the state budget, which provided additional political support for these initiatives, given that both states are now facing growing budget deficits.
2. These programs also have the advantage of being large enough to generate substantial savings, providing each state with a “proof of concept” experience with provider rate setting, demonstrating that these models can be easily administered and effective in maintaining or improving the affordability of health insurance coverage when applied to segments of a state’s healthcare sector, but small enough to avoid a full-scale political assault by the hospital industry in each state.
3. If the State’s experience parallels that of Oregon, Washington will improve the affordability of a key public insurance program while also saving State funds. These savings can be redeployed to avoid increased beneficiary premiums and cost-sharing and assist the State in financing additional budget shortfalls due to cuts in federal Medicaid funding.¹²
4. Both the Oregon and Washington RBP Cap programs are designed to be easily administered (i.e., the state’s Third-Party Administrators are given the responsibility to ensure compliance), thus giving these states valuable experience implementing a government-administered and regulated hospital pricing programs which they can build on in an incremental way to design broader healthcare spending control models.

Both Oregon and Washington used these arguments to pass their RBP Cap legislation for their State and Public employee health benefit programs.¹³ The legislative efforts of these states may well encourage other states to pursue RBP Caps for their SHEBPs.

In addition to Oregon and Washington, bills to establish RBP caps on state employee health plans were filed last session in Maine, Delaware, Colorado, Nevada, Massachusetts and New Jersey. Other states, such as New Mexico, have begun to pursue forms of RBP Caps in their state employee health plans through administrative action, rather than legislation. New York state also introduced a RBP Cap bill designed to create site-neutral payments for hospital outpatient services. These legislative initiatives authorized state government to cap the amounts that hospitals can charge payers or patients,¹⁴ allowing them to avoid federal ERISA restrictions on states’ ability to regulate self-funded ERISA plans.ⁱ In addition to these efforts to improve

i The New York Travelers Insurance ERISA challenge in New York, which argued that state hospital rate setting was pre-empted by the federal ERISA statute, was ultimately overturned by the Supreme Court of the U.S. Per this Supreme Court ruling, it was determined that while state insurance regulatory authority over self-funded plans was indeed preempted by ERISA, states are allowed to legislatively mandate what hospitals are allowed to “charge” private payers, including self-funded ERISA plans. This ruling enabled the state of Maryland to continue to operate its hospital rate setting system and avoid an ERISA preemption.

the affordability of SHEBPs, other states, such as Indiana and Vermont, have passed legislation to apply RBP Caps, tied to Medicare pricing, to truncate high hospital prices paid by private insurers across the entire private market.¹⁵

As an aside, we would also note that at the federal level, it appears that federal health benefit programs could also generate significant savings if programs such as the Federal Health Benefits Program (FEHBP) made use of RBP Caps for hospital payments. The Committee for a Responsible Federal Budget analyzed reference pricing for the FEHBP, estimating that capping at 200% of Medicare over the decade 2026–2035 could reduce federal spending by \$60 billion and reduce enrollee costs by an additional \$30 billion through lower premiums and out-of-pocket costs.¹⁶ These are staggeringly large potential savings and the Office of Personnel Management (OPM), the agency that runs the FEHBP should submit legislation to implement this type of cost savings initiatives for federal workers and retirees.

4. Evidence on Financial Impact of RBP Caps and Hospital Responses

Research credited the Oregon law with generating \$50 million in annual savings for the state and resulting in “small and nonsignificant changes in Oregon hospitals’ revenues, expenses and margins after implementation of the cap.” A study from Brown University’s School of Public Health calculated that if adopted nationwide, hospital payment caps could save other states substantial amounts – about \$150.2 million per state based on data from 46 states and Washington, D.C., ranging from \$2.7 million in Rhode Island to \$933 million in California.¹⁷

Hospital industry opposition has been consistent across states. Oregon hospital advocates blamed the law for deteriorating finances at those facilities and which they believe threaten hospital closures, and made the following observation: “This research is disconnected from reality and tone deaf, coming at a time when half of Oregon’s hospitals are consistently operating in the red,” per a representative of the Hospital Association of Oregon.¹⁸ The Delaware Healthcare Association said a 250% Medicare cap would cut \$413 million in healthcare services for Delaware hospitals and risk 4,000 jobs. The Colorado Hospital Association raised concerns about the use of Medicare as a benchmark since they believe that Medicare payments fall far short of covering the cost of care.¹⁹

Yet, these criticisms overlook the fact that all RBP Cap proposals set price constraints at a multiple of comparable Medicare price levels. The level at which the Medicare multiple is set (185%, 200%, 250%, 260%) determines whether a cap is genuinely constraining or merely symbolic for many hospitals. More importantly, as noted, the structure of the benchmark — whether it uses final, adjusted Medicare payments including wage index, DSH, GME, and capital adjustments,

or some standardized simplified rate — will determine whether the caps are equitable across hospital types, financially sustainable for safety-net and teaching institutions, and administratively workable. There is a strong case that for caps to be fair and durable, they should use final, fully adjusted Medicare IPPS/OPPS payments (including the six core adjustments listed previously) rather than using a simplified national average, while providing explicit carve-outs or enhanced multipliers for critical access hospitals, sole community providers, and major teaching centers.

As discussed, variations on these models are being explored in other states, potentially establishing a nationwide patchwork of commercial price caps that could eventually form the basis for a broader framework for federal policy. The 2026 legislative session may represent a critical inflection point. With at least twelve states having considered legislation in 2025 and several more advancing proposals in 2026, hospital reference-based pricing has moved from a niche administrative strategy to a mainstream legislative priority — driven by the fact that commercial hospital prices in most markets are, by any objective measure, far in excess of what is needed to provide high-quality care.²⁰

5. Key Design Issues with RBP Caps

Price Caps are a regulatory system used in both public utility rate setting and other industries such as healthcare. Price Caps set a maximum price that providers can charge for identified services (either all private insurer payments or a more limited application focusing on Capping just OON Prices). Such a system is generally defined in granular way (i.e., for each individual hospital service).

As noted, reference pricing sets payment levels tied to a specified benchmark, which is often defined as a multiple of Medicare's FFS hospital rates. Again, RBP Cap models have thus far primarily targeted specific payer groups, such as a state's employees and other public employee health benefit programs. Most states have structured RBP Caps to impose a ceiling on how much providers can charge payers, rather than the rate that insurers pay. This recommended legislative language (i.e., setting constraints on how much a hospital can charge and accept as payment) should be adopted because the Supreme Court rulings regarding past ERISA challenges to rate setting found that while states cannot regulate the amount that self-funded health plans pay providers, the ERISA pre-emption clause is not triggered by direct state regulation hospital's charging practices.²¹

RBP Caps have the following advantages for states looking to gain experience with a low-intensity rate setting model. First, RBP Caps address the most extreme prices, truncating them,

while leaving prices below these highest levels in place. States enacting RBP Cap legislation have specified administratively that the enforced Price Caps are the lower of the RBP Cap level, billed charges or the historical price in place before enactment of the law. This administration clarification can help avoid what is referred to as a “Sentinel” pricing phenomenon, where a provider is allowed to raise prices below the Cap, up to the cap.

Second, RBP Caps tied to comparable Medicare hospital prices are administratively less complicated and time-consuming to implement because in addition to reflecting the cost of production, Medicare prices are well-known and easily determined. Additionally, Medicare prices reflect both the underlying relative cost of production but also takes into consideration a number of external factors that influence hospital costs that are largely outside the control of hospitals, such things as area wage and capital cost variations, adjustments for different uncompensated care and graduate medical education funding levels experienced by hospitals. Thus, RBP Caps tied to Medicare are fairly set because they reflect hospitals legitimate production costs.

Despite the relative simplicity of first using RBP Caps to control hospital prices and spending, this model is less amenable to the application of certain adjustments to rates to achieve certain related policy goals. First, although theoretically possible, it will be more complicated for hospitals to overlay an adjustment to reduce the FFS incentives to increase volumes that will face providers under a RBP Cap model. This is also true for other helpful programs and adjustments, such as the incorporation of a system of funding reasonable levels of hospital uncompensated care through the use of surcharges on rates and/or hospital uncompensated care pools and the implementation of a Quality Pay-for-Performance system. Both possible methodological additions are discussed later in this report.

Although RBP Caps are easier to implement than a system of “home grown” hospital rates, developed from scratch as occurred in all rate-setting states in the 1970s and 1980s, they still require an elaborate and complex rate reporting and compliance capability by at state and the Third-Party Administrators (TPSs) charged with overseeing the system.

There is also a question of how a RBP Cap model is best updated over time? The Oregon approach assumes that an inflation of the state’s RBP Caps will make use of the annual federal updates to the Medicare IPPS and OPPI rates. We assume that the actual overall Cap will be increased by the approved annual federal update to IPPS and OPPI and that all prices below the RBP Cap will be frozen in place during the year but receive the same approved IPPS/OPPI annual inflation increase. Historically, Medicare hospital inpatient and outpatient updates have been extremely low relative even to actual annual hospital factor cost inflation increases. Thus,

states will face significant pressure from providers to add to the annual inflation update, if this trend continues.

Additionally, concerns have been raised about the potential impact on safety-net and rural hospitals, facilities that are currently receiving lower reimbursement rates and may be struggling financially. Oregon, Washington and Vermont have attempted to address this issue by exempting certain smaller and low volume hospitals from the RBP Cap program.

Finally, policymakers in Oregon were concerned that the application of RBP Caps to the state and public employee program only, would result in a degree of “cost-shifting” (i.e., hospitals raising their negotiated prices with other health plans in the general private market) to offset lower state and public health benefit program rates. While this is a legitimate concern, follow-up analysis of the program has not identified this type of pricing response by Oregon hospitals subject to the RBP Cap program.²²

C. Step 2: Participation of all Public Insurance Plans in the RBP Cap Program

Once an RBP Cap program is operational and demonstrating the ability to constrain hospital prices, states have the ability to apply their RBP Cap programs to other public entities in the state, such as county and local governments and public educators. This expansion can be achieved without further legislation and will help improve the viability of these other public insurance programs and further demonstrate the effectiveness of RBP Caps to control hospital price and spending growth, without imposing deleterious impacts on hospitals. A state implementing a RBP Cap program for its SHEBP should actively recruit these and other governmental entities to participate in the program, further demonstrating the potential success of this low-intensity rate setting approach. In addition to local municipal governments, county governments and their workers can be eligible for Washington’s RBP Cap protections. King County, which encompasses the city of Seattle, has already expressed interest in participating in the RBP Cap program legislated by the state in 2025. Unfortunately, extending RBP Caps to private payers or self-funded plans will require additional authorizing legislation, as discussed below.

Currently, we believe that extension of RBP Caps to private sector entities, such as private insurers or self-funded insurance plans (i.e., Taft-Hartley Plans or other Self-insured employers, which tend to be large and make use of a Third Party Administrator to pay claims and handle other administrative functions) will require either the development of a Public Option that these plans can “buy-into” or specific legislation authorizing the use of RBP Caps that control what hospitals can charge these private payers.

D. Step 3: Legislation to Apply RBP Caps on Out-of-Network (OON) Hospital Prices

In keeping with the State's desire to implement price and spending constraints in an incremental fashion, the next step a State could take would be to pass legislation imposing RBP Caps linked at a proportion of Medicare hospital payment levels, to all OON payments made by private insurers licensed to operate in the state. Once again, such legislation should mandate what hospitals are able to charge for OON hospital services, as opposed to attempting to directly regulating what insurers must pay. As discussed, this is because the federal ERISA law of 1974 preempts state regulation of self-funded ERISA plans. However, as noted, this preemption can be circumvented if state legislation focuses its authority to mandate what hospitals can charge and accept as payment.

As noted in the introduction to this section, there is strong evidence from the imposition of OON price caps in the Medicare Advantage market that shows that legislation mandating the application OON price caps can strengthen the negotiating leverage of private insurers relative to hospitals and result in lower year-over-year increases in private insurer spending on hospital care.²³ Although OON hospital care only accounts for between 6-9% of hospital spending, capping OON hospital prices can help neutralize an effective tactic that hospitals use in their price negotiations with insurers, threatening to terminate their insurance contract, go out-of-network and charge the insurers' beneficiaries full charges (which are often double or triple contracted prices). Facing the prospect of spending much higher amounts on hospital care, and a reduction in the insurer's network – an undesirable result for most fully insured and self-funded accounts -- insurers regularly acquiesce to hospital demands for large increases in their contracted rates. Setting an OON price cap at, say, 200% of Medicare would mean that the insurer could easily demand contractually negotiated prices covering both in- and out-of-network services at or below 200% of Medicare. This is because if the hospital refused such an offer from the payer, the OON Price Cap law would require a payment of no greater than 200%.

This proposed third step is considered a "lower intensity" rate regulatory strategy because it would only apply to the small proportion of private insurance payments that are OON.^{24,25} However, the leveraging impact of improved insurer negotiating leverage over contracted in-network hospital rates will help curtail the rapid annual hospital price escalation insurers face due to the market dominance of an increasingly consolidated hospital industry. The use of RBP caps, at a specified proportion of Medicare, could also overcome the flaws in the federal No Surprises Act (NSA) which has been ineffective because it defaults to an Independent Dispute Resolution (IDR) process that is costly, cumbersome, results in determinations that largely favor hospitals and thus fails to adequately cap surprise bills.²⁶ The use of a RBP Cap approach would

remove the subjectivism biases of IDR arbitrators that have been decidedly in favor of providers. These weaknesses have plagued the IDR process since it was established in 2022.²⁷

E. Step 4: Applying RBP Caps on Hospital Payments to all Private Insurers

Recently, Vermont passed legislation directing the state's independent healthcare regulatory board, the Green Mountain Care Board (GMCB) to implement RBP Caps (linked to a proportion of Medicare hospital payment levels) on all private insurance hospital payments in the state beginning in 2027.²⁸

As we have suggested, after gaining experience with RBP caps for state/public employees and possibly an extension of this authority to OON hospital prices, states should introduce comparable RBP Cap legislation applicable to all hospital payments by private insurers and self-funded plans. However, as in the case of Vermont, states can move directly to implementing legislation to give the state authority to set RBP Caps on all private insurer payments to hospitals. The state's implementation of this type of hospital payment model may also be facilitated by the development of an independent Commission or Board, similar to Vermont's GMCB, to oversee such a rate regulatory program. Such an independent agency would be well-suited to oversee and enforce compliance with a system of RBP Caps on all hospital prices for private insurer hospital payments and any future government-administered hospital spending control systems.

RBP Caps can be set at levels that are appropriate for each state, balancing the need for hospital price and spending constraint while at the same time gradually imposing appropriate limits on hospital prices. As noted, such a regulated pricing system should be applied to all fully insured private accounts and to participation by self-funded accounts.ⁱⁱ An RBP Cap program linked to Medicare hospital payment levels, has the following key advantages:

1. This system is easy to implement and administer avoiding the tendency of past state efforts to construct elaborate hospital price control models that become ineffective because of their complexity;
2. The system can be implemented without the need for a large governmental staff to operate and enforce compliance with the system;

ii Although the New York Travelers Insurance ERISA challenge which argued that state rate setting was pre-empted by ERISA was ultimately overturned by the Supreme Court of the U.S., the supreme court ruling on this case did allow states to determine the rates that hospitals are allowed to charge for services to beneficiaries of ERISA Plans, without the danger of an ERISA preemption.

3. Different price cap levels can be established for different types of hospitals, even resulting in price increases for certain financially challenged institutions (such as small/rural hospitals) in the state;
4. Linking all private sector hospital payments in the state to Medicare prices can also be the basis for a set of far more equitable and rational system of regulated hospital “base” (or “initial”) rates.ⁱⁱⁱ This system of private sector base rates can be parlayed into a broader hospital rate regulatory system with an independent Board or Commission overseeing, administering and ensuring hospitals and payer comply with the system; and
5. If a state is able to transition from RBP Caps to a system of regulated base and regulated hospital unit rates, it can implement various supplementary adjustments, such as a Volume Adjustment System (VAS), to counter the inherent incentives in fee-for-service (FFS) payment models to induce hospitals to unnecessarily increase their volume of services to improve their profitably.

Once a system of more rational and equitable hospital base rates is established for private insurer patients, the state could consider the implementation of other rate setting adjustments, methodologies and policy programs. Transitioning RBP Caps to a system of Base Rates, which set a single price (both a ceiling and floor) for each hospital service would be the first change states should consider (see section III below). Once this is accomplished, a state can incorporate an important overlay adjustment, the Volume Adjustment System or VAS, to counteract the incentives of FFS payment to induce unnecessary hospital utilization.

One additional program the state should consider would be a method of assisting hospitals in the funding of UC. Given the cutbacks in subsidized private insurance and Medicaid programs, hospital UC is likely to increase rapidly in future years. Such a system will be increasingly attractive to hospitals as their UC grows rapidly over time and can support the financial viability of hospitals that service patients in rural and underserved areas of the State. The one major caveat to the implementation of a system of assessments to fund hospital UC, which we will discuss, is that a hospital UC funding system is best implemented when a state has the authority to set

ⁱⁱⁱ Medicare payment levels have the distinct advantage of being set with a consistent relationship to actual relative cost levels by service. A set of private sector rates linked to Medicare, then can help eliminate existing price distortions and inequities of privately negotiated hospital prices, which has resulted in an array of prices that do not reflect the cost of delivering a service and result in severe misallocations of resources and other distortions. A regulatory board or commission can oversee such a system and gradually phase all hospital rates to reflect a consistent proportion of Medicare payment levels and thus create a far more rational (from an economic standpoint – i.e., in markets, prices that reflect cost result in a better allocation of resources and more equitable payments) hospital payment system.

rates broadly across all-payers. Thus, we would recommend that states wait until they gain approval for an All-Payer Medicare Waiver before attempting to implement such a program.

F. Step 5: Application to CMS/CMMI for an All-Payer Waiver for Hospital Payments

Once a state has organized and operated a system of more equitable and rational base hospital rates using a RBP cap approach, and assuming the election of a new federal administration more favorable to government regulatory efforts to control healthcare spending, the state should consider applying to CMS and the CMMI for a Medicare/Medicaid Waiver to allow the State's Health Authority or an independent Commission or Board, to set and control the rate of growth of all hospital payments across all-payers. An all-payer system has the distinct advantage of creating more consistent and rational payments and rate control policies and the ability to spread the burden of financing hospital UC more equitably. A Medicare Waiver is a required element of any state's strategy to develop effective Hospital Global Budgets (HGBs). However, an effective HGB model must allow a state to have regulatory authority over Medicare and Medicaid pricing, in addition to its state-initiated authority to regulate private insurer charges by hospitals.

If states can successfully gain approval of a Medicare Waiver, they can create a system of "Flexible" HGBs, utilizing the VAS for hospital payments from private insurers, as well as from Medicare and Medicaid. As we have noted repeatedly in Part 1 of this report, we believe a system of Flexible HGBs, which operated successfully in Maryland from 1976-1992, has distinct advantages over the Fixed HGBs implemented by Maryland more recently in 2014.^{iv} While the Maryland Fixed HGBs did save Medicare money over time, these savings were generated on Medicare payments that had traditionally been 30% higher than average Medicare hospital payment nationally. Thus, these savings were achieved in an environment where Medicare already drastically overpaid Maryland hospitals for Medicare services. More importantly, the use of a more flexible and less severe approach can avoid the risk that hospitals might unnecessarily stint on care or overtly shift care to non-hospital providers. Both circumstances have occurred in Maryland and in other jurisdictions where fixed HGBs have been implemented.

^{iv} Throughout this report we refer to the hospital global budget models adopted in Maryland as "Fixed" HGBs, which implies that hospital budgets, once set each year, did not vary at all for changes in volume. In actuality, the Maryland HGBs did include small annual adjustments that allowed a hospital's revenues to vary by amounts from year to year for changes in each hospital's patient demographics and for estimated "shifts" in patient volume from one hospital to another. Again, these annual revenue adjustments were quite small and generally unpredictable. Accordingly, we characterized the Maryland hospital budgets as "Fixed" HGBs throughout the remainder of this report, because the HGBs created extremely strong incentives for hospitals to reduce all hospital volumes by any means possible.

We now turn to a detailed discussion and description of the workings of how a state implementing RBP Caps for covering what hospitals must charge private insurers can use RBP Caps to transition to a system of regulated hospital payments per unit of service and a system of more equitable and rational hospital base rates. As noted, once a state transitions from RBP Caps to a system of regulated base unit rates, it can begin to incorporate other beneficial rate setting mechanisms and methods such as the use of a Volume Adjustment System, which was the mainstay of the HSCRC early rate setting system which contributed to Maryland's greatest period of cost containment success over the 50 years of the HSCRC's rate regulation experience.²⁹

III. Complementary Rate-Setting Policies States Can Implement

A. Transitioning from a RBP Cap Model to Set Hospital Base (i.e. Initial) Rates

1. Background

A state-regulated system of RBP Caps, linking private sector hospital payments to comparable Medicare payments, at a multiple of Medicare, serves as price and spending constraints. It also has the supplemental benefit of providing the basis for the transition to a system of more equitable and rational regulated unit rates, similar to the hospital rate setting structures developed by Maryland, New Jersey, New York and Massachusetts in the 1980s and 1990s, or by the Medicare program, beginning with the implementation of its Inpatient and Outpatient Prospective Payment systems in 1984 and 2000 respectively.

These rate setting systems set and regulated a rate per unit of service, (e.g., a regulated price per hospital discharge, emergency room visit or diagnostic test). This approach established both a ceiling and a floor on regulated payment levels, treats hospital services as commodity prices and defines an actual payment amount per hospital service provided, as opposed to RBP Caps which only place an upper limit on prices. Establishing a system of base and regulated unit rates, will not only create a higher level of pricing equity across all services, but it will also give a rate setting agency additional flexibility to modify and augment its rate setting approaches over time.

As noted, the current system of negotiated private insurer payments to hospitals are characterized by significant variation, with prices that primarily reflect the relative market power and pri-

ities of hospitals, which dominate the price negotiations with private insurers. As a result, the current hospital prices are inequitable and irrational, in the sense that they do not resemble the prices that would be set in a competitive market. As we have noted, competitive markets set prices by allowing supply and demand to interact to drive prices to a point where the marginal cost of production equals the marginal benefit to consumers. This dynamic process results in prices that reflect the actual relative cost and resource used by providers to produce services. It also allows for the efficient allocation of resources to the highest-valued uses, maximizing economic efficiency and eliminating waste by incentivizing firms to lower their costs, to compete against other producers. These dynamics are lacking in the current non-competitive market for hospital services.

However, as noted, Medicare prices more closely resemble competitive market prices in that they are service-specific and based on hospital relative production costs. Thus, Medicare prices will, in general, result in a more efficient allocation of resources than the current and highly distorted privately negotiated hospital prices. While the use of price caps can certainly improve the affordability of hospital care in a state, the use of RBP Caps alone will create an incomplete and likely less successful version of a rate regulatory system. Thus, it is important that also consider transitioning this system of RBP Caps to a system of more equitable and rational regulated base unit rates for each hospital service. This section will provide a discussion of how states might transition to a set of more equitable and rational regulated hospital base rates.

2. Options for Transitioning from RBP Caps to a System of Equitable Regulated Base Rates

The following section describes a rate setting proposal for the state of Vermont, to allow the state to transition from a contemplated system of RBP Caps, that set upper limits on how much Vermont hospitals can charge private insurers to a system of regulated base rates. Again, we believe the use of Medicare prices as a benchmark can give a state the opportunity to eventually create a very rational and equitable system of regulated base/initial payments. It can also serve to allow a state like Vermont, to augment its rate regulatory system by applying additional adjustment mechanisms and incentive programs that will help the state meet both its cost containment and other policy goals.

Given its existing rate setting authority and the recent directive from the Vermont legislature to establish a regulated “Reference-Based Pricing” (RBP) system for all commercially insured hospital payments, the Vermont GMCB could intervene to protect consumers by regulating hospital prices to private sector patients in a system with the following principles and features:

Simplicity: The system should minimize the staff and the technical expertise required for system administration. This approach anticipates that the regulated hospitals would assume much of the burden of reporting on and ensuring compliance with the RBP Caps. Any additional administrative costs to be incurred by the hospitals by taking this approach would be minimal, relative to their overall budgets and to the benefits brought to consumers by the system.

Coverage: The system would be mandatory for all of Vermont's eight Critical Access and six IPPS hospitals, and the following payer categories: All State and Public Employee benefit programs; all fully insured and uninsured private sector patients; and any "cost-plus"/ERISA plans subject to the right of such employers to participate or not participate.^v

Stratification of Price Levels: The system of rate controls should distinguish among hospitals with regard to their current estimated levels of private sector rates relative to Medicare payments for similar patients. The hospitals could be grouped into three categories: (1) High-Priced Hospitals; (2) Medium-Priced Hospitals; and (3) Low-Priced Hospitals. Each of these categories would be separately established for each of the High-Priced hospitals and the Medium-Priced hospitals for inpatient (IP) and outpatient (OP) services. Low-Priced hospitals would be categorized on a combined IP and OP services.

Method of Stratification: Hospitals would be deemed to be in one of the categories described above based on either: 1) the most recent results of the RAND analyses of the relationship of hospital private sector rates for IP and OP services relative to Medicare; or 2) a Base Year Report to be completed by each hospital and submitted to the Board.³⁰ Eventually, each state should benchmark the prices paid by private insurers to each hospital relative to comparable Medicare hospital pricing in order for this stratification to be a complete analysis of all hospital prices paid by private insurers in the state.

Transition of High and Low Prices to Acceptable Base Rates: Perhaps the most politically and financially important design question is how to transition from current inflated prices to RBP Cap levels without triggering hospital closures, service line reductions, or abrupt access disruptions. Again, while a state should use the results of a RBP Cap rela-

^v As noted previously, we believe based on past rulings by the Supreme Court that a legislative provision that mandates what hospitals can charge and accept as payment in the context of a state system that sets price caps or directly regulates state-established payment levels should minimize the risk from an ERISA challenge.

tive to a multiple of Medicare prices as the basis for the transition, the end result would produce actual regulated base/initial prices per unit of hospital service.

3. Baseline Assessment and Segmentation

Before any price cap is imposed, the regulatory authority should pursue the following steps:

- Map current commercial rates at each hospital relative to Medicare, using All-Payer Claims Database data or insurer rate filings — and establish a clear baseline pricing scenario. The RAND Employer Pricing Survey can be an initial data source used by states to evaluate their private insurer pricing levels relative to Medicare. However, each state should develop a complete schedule of hospital inpatient and outpatient prices, relative to comparable Medicare prices, for all hospitals.
- Stratify hospitals by their current pricing levels as a proportion of comparable Medicare payments (see the data in Tables 3a – 3c below, from the RAND Employer Survey of Hospital prices benchmarked to Medicare).
- Further stratify hospitals by financial position: operating margin, days cash on hand, debt service coverage ratio, payer mix.
- Identify the most vulnerable hospitals — particularly rural hospitals, safety-net hospitals, and small community hospitals already operating on thin margins.
- Model the financial impact of RBP Cap levels on each hospital's revenue under various scenarios for all groups of hospitals.

4. Base Year Report (BY Report)

The purpose of the Base Year (BY) Report would be to establish the relationship between each hospital's payments for the patients covered by this system and the payments the hospital would have received from Medicare for such patients if they had been covered by Medicare. The Medicare payments to be considered would exclude payments made by or on behalf of patients covered by a Medicare Advantage (MA) plan.

The first base year (BY) in this example is assumed to be for Federal Fiscal Year (FFY) 2025. The BY Report would require each hospital to submit the following summary information for the BY:

- Payments received from the patients covered by this legislation for services with dates of service (DOS) that occurred during FFY 2025 inclusive of any claim "runout" available by the filing date of the BY Report.
- These payments shall be separately reported for IP and OP services and on a combined

IP and OP basis. The payments reflect that would have been received from Medicare if the patients covered by this legislation had been covered by Medicare.

- The ratio of the payments received from the patients covered by this legislation and the payments that would have been received from Medicare.
- The absolute dollar difference between the payments received from the patients covered by this legislation and the payments that would have been received from Medicare.

The BY Report would be supplemented by a machine readable file, in a format to be specified by the Board, that would show (a) the number of IP patients covered by this legislation on an MS DRG-specific basis using the MS DRG grouper applicable under Medicare to the BY and the payments received by the hospital for these patients; and (b) the number of units of service provided on an OP basis to patients covered by this legislation on a CPT/HCPCS-specific basis with relevant modifiers as needed to calculate the payments that would have been made by Medicare for these patients.

The data to be provided in the BY Report would be compiled by the hospitals themselves or with the assistance of consulting firms or other organizations with technical expertise and experience in the modeling of Medicare payments for non-Medicare patients. The Board would supply the hospitals with the names of firms approved by the Board for this work. The BY Report would also be due to the Board from each hospital not later than one hundred twenty (120) days after the end of the BY. The Board would have the right to arrange for audits of the BY Reports submitted by the hospitals. The audits would be conducted by audit firms approved by the Board. All audit reports would be submitted directly to the Board with copies to the hospital covered by the audit. The fees associated with the audits would be paid by the affected hospitals and would be paid to the Board which would pay the fees to the audit firms.

Two senior officials of each hospital (the CEO/President and the Senior VP of Finance or the equivalent official) would be required to attest to the accuracy of the BY Report under the pains and penalties of perjury and any other sanctions or penalties to be imposed by the Board.

Sample of a Base Year Report: Results from RAND Survey of Hospital Prices for Vermont for 2020, 2021, 2022

Prior to the development of a Base Line Report, detailing each hospital's average private insurer price, for both inpatient and outpatient services as a multiple of comparable Medicare hospital pricing, a state can make use of the results of the most recent RAND Employer Survey of Hospital Prices. The following tables provide the results for 8 of Vermont's 14 acute care

hospitals for the years 2020 to 2022. For illustrative purposes, we have stratified services into inpatient and outpatient (given the large initial difference in pricing between these two sectors) and into high-priced, medium-priced and low-priced hospitals. These preliminary pricing results are shown below.

Table 3a: Overall Vermont Hospital Price Levels Benchmarked as a Proportion of Medicare

	2020	2021	2022
All Vermont Hospitals in Survey Inpatient	200%	209%	227%
All Vermont Hospitals in Survey Outpatient	293%	304%	311%
Combined IP/OP prices	254%	269%	283%

Note, per NASHP Hospital Breakeven estimated to be 150% of Medicare

Table 3b: Vermont Hospital Prices for Inpatient Services – 2020-2022

	Hospital Inpatient Prices	Type of Hospital	2020	2021	2022	Category
Tier 1	University of Vermont	IPPS	216%	229%	248%	High Priced
	Southwestern Vermont	IPPS	220%	231%	227%	High Priced
	Rutland	IPPS	193%	202%	211%	High Priced
	North Country	CAH	191%	196%	203%	High Priced
Tier 2	Dartmouth University, NH	IPPS	144%	147%	159%	Medium Priced
	Gifford	CAH	153%	159%	NA	Medium Priced
	Northwest Med. Ctr. (St. Albans)	IPPS	123%	138%	142%	Medium Priced
Tier 3	Independent CAH	CAH	128%	116%	98%	Low Priced

Table 3c: Vermont Hospital Prices for Outpatient Services – 2020-2022

	Hospital Outpatient Prices		2020	2021	2022	Category
Tier 1	University of Vermont	IPPS	329%	348%	357%	High Priced
	Rutland	IPPS	332%	332%	351%	High Priced
	Southwestern Vermont	IPPS	331%	309%	345%	High Priced
	North Country	CAH	296%	196%	203%	High Priced
Tier 2	Dartmouth University, NH	IPPS	246%	250%	256%	Medium Priced
	Northwest Med. Ctr. (St. Albans)	CAH	228%	251%	252%	Medium Priced
Tier 3	Gifford	CAH	153%	159%	NA	Low Priced
	Independent CAH	CAH	154%	157%	155%	Low Priced

Note: the RAND Survey only included eight of Vermont's 14 hospitals.

6. Need for a More Graduated Glide Path to Rational Pricing

The results from the 2020-2022 RAND Employer survey of hospital prices, benchmarked to comparable Medicare prices, shows results for eight of Vermont's 14 acute care hospitals. As shown in Table 3a above, the state has combined inpatient and outpatient prices that were approximately 283% of Medicare. This is much higher than the combined inpatient and outpatient prices for all hospitals in the survey, nationwide, which were approximately 254% in 2022.³¹ The University of Vermont Medical center is clearly the highest priced hospital in the state with inpatient prices at 248% of Medicare for inpatient services and outpatient prices at 357% of Medicare in 2022. These price levels are astoundingly high, particularly when compared to the price levels of a comparable institution, the Dartmouth-Hitchcock Medical Center, with inpatient prices at 159% and outpatient prices at 256% in 2022.

In transitioning these hospital inpatient and outpatient prices to an acceptable multiple of Medicare prices over time, the state should construct a phase-in timeline that is appropriate for such diverse hospital pricing and financial situations. Based on the RAND data, Vermont might stratify its hospitals into high-, medium- and low-price tiers, as shown above and further differentiating hospital prices into inpatient and outpatient categories.

In all states, it appears that existing outpatient hospital prices are significantly above the levels of inpatient prices as a proportion of comparable Medicare prices. This may be an artifact of the negotiation process between hospitals and insurers. It may also be a function of Medicare outpatient pricing which has been acknowledged to be lower than Medicare. The Medicare Payment Advisory Commission's (MedPAC) analysis has shown that Medicare's outpatient hospital payment-to-cost ratio has been lower than its inpatient ratio. Both have consistently been negative, but the outpatient shortfall has generally been larger.³² This result may also contribute to the fact that hospital prices negotiated by private insurers result in a higher Medicare multiple than exists for inpatient Medicare prices. Regardless of the cause, the much higher outpatient price levels paid by private insurers, relative to Medicare hospital payment, may require application of a separate "glide path" for outpatient and inpatient prices, if a state decides to transition RBP Caps to a common set of base rates over time.

But, given the large difference in pricing across hospital services and for inpatient relative to outpatient services, a single uniform phase-in timeline is inappropriate for the hospital market. A differentiated and equitable glide-path to a schedule of more reasonable rate levels in order to reduce or eliminate the pricing distortions that have accrued over time due largely to market negotiating dominance of highly consolidated hospitals and systems. The sections below outline a potential glide path for hospital pricing.

7. Example of a Stratification of Vermont Hospitals

Cutoff points would be established, using the relationship between hospital private sector payments (i.e., payments made by or on behalf of the patients covered by this legislation) and what they would have been paid by Medicare for the same patients, as calculated either by RAND or using the data submitted by the hospital in the BY Report, and the hospitals would be classified on the basis of that information as follows:

- Hospitals with Inpatient (IP) rates at or above 200% of Medicare would be defined as High Priced IP Hospitals.
- Hospitals with Outpatient (OP) rates at or above 300% of Medicare would be defined as High Priced OP Hospitals.
- Hospitals with Inpatient rates below 200% of Medicare would be defined as Medium-Priced IP Hospitals.
- Hospitals with Outpatient rates below 300% of Medicare would be defined as Medium-Priced Cost OP Hospitals.
- An additional category of hospitals could be established as follows: Hospitals with rates at or below 160% of Medicare on a combined IP and OP basis would be defined as Low-Priced Hospitals.

In the first year in which the system would control hospital private sector payments, i.e., Rate Year 1 (RY 1), hospitals would be required to set their inpatient and outpatient rates at the following prescribed ratios of what Medicare would have paid for the same patients:

- High-Priced IP Hospitals: At the ratio of Medicare payments that would bring their ratio of private sector payments to Medicare payments down on an equal annual basis from its BY Report level to 200% of Medicare over a five (5) year period or over a longer period specified for the hospital by the Board.
- High-Priced OP Hospitals: 300% of Medicare: At the ratio of Medicare payments that would bring their ratio of private sector payments to Medicare payments down on an equal annual basis from its BY Report level to 300% of Medicare over a five (5) year period or over a longer period specified for the hospital by the Board.
- Medium-Priced IP Hospitals: At the ratio of Medicare payments shown in the BY Report of the hospital.
- Medium-Priced OP Hospitals: At the ratio of Medicare payments shown in the BY Report of the hospital.
- Low-Priced Hospitals: At the ratio of Medicare payments shown in the hospital's BY Report plus an additional amount, relative to Medicare, to be prescribed by the Board,

with such additional amounts to be limited such that the hospital's private sector rates do not exceed 175% of Medicare in any particular RY.

8. Proposed Glide-Path Transitional Methodology of Rate Controls (for illustration purposes)

Some states, such as Oregon and Washington, making use of a RBP Cap rate setting structure, benchmarked to Medicare, have targeted an overall desired rate level of 200% of comparable Medicare prices (for both inpatient and outpatient hospital services). It may make sense for a state like Vermont, experiencing even higher levels of private sector hospital prices, to target a slightly higher initial endpoint for outpatient, relative to inpatient prices. The following suggested transitional schedules apply to a potential transition of inpatient prices to the targeted level of 200% of Medicare. A similar schedule can be developed for transitioning outpatient prices from their extremely high levels to a slightly higher targeted endpoint, say 250% of Medicare.

9. Potential Outpatient Pricing Glide-Path

For outpatient hospital services, assuming an end target of 250% of Medicare for all hospital outpatient prices in the state, for the most financially robust, highest-priced hospitals (e.g., those currently charging >300% of Medicare), the state might impose the following transitional schedule of inpatient hospital prices:

Year 1: Freeze at current levels
Year 2: Reduce to 333%
Year 3: Reduce to 300%
Year 4: Reduce to 275%
Year 5: Reduce to the 250% target cap level

For medium-priced hospitals (currently charging 200–250% of Medicare):

Year 1: Freeze at current levels
Year 2: Reduce to 240%
Year 3: Reduce to 225%
Year 4: Reduce to 210%
Year 5: Reduce to 200%

For lower-range and potentially financially vulnerable hospitals (low margin, high Medicaid/rural):

- Initial cap set higher than current reimbursement levels: (e.g., 200% depending on the analysis)
- Slower phase-in timeline
- Eligibility for state supplemental payments or transition assistance fund^{vi}

a) Potential Inpatient Pricing Glidepaths

For inpatient hospital services, assuming the end target for all inpatient prices in the state is 200% of Medicare, for the most financially robust, highest-priced hospitals (e.g., those currently charging >250% of Medicare), the state might impose the following transitional schedule of inpatient hospital prices:

Year 1: freeze rates at current levels.

Year 2: Reduce to 240% maximum (hard freeze on further increases)

Year 3: Reduce to 230%

Year 4: Reduce to 220%

Year 5: Reduce to the 200% target cap level

For medium-priced hospitals (currently charging 200–250% of Medicare):

Year 1: Freeze at current levels

Year 2–4: Reduce to 225%

Year 5+: Reduce to 200%

For lower-range and potentially financially vulnerable hospitals (low margin, high Medicaid/uninsured, rural):

- Initial cap set higher (e.g., 175% depending on analysis)
- Slower phase-in timeline
- Eligibility for state supplemental payments or transition assistance fund

For Critical Access Hospitals:

- Maintain cost-based reimbursement principles; do not apply the same percentage-of-Medicare cap.
- Consider a separate flat-dollar or cost-report-based framework,

^{vi} An example of a supplemental support program is Maryland's Nurse Support Program (NSP). To counter an identified cycle of shortages of nursing and ancillary support staff, the Maryland rate setting Commission created a fund, from assessments on hospital rates, which could be used by hospitals with nursing schools to offer scholarships and tuition assistance to incentivize the training of needed clinical personnel. Over time, this program helped offset the historical cycle of clinical personnel shortages and helped hospitals reduce their staffing costs and reliance on nursing agencies.

b) Compliance Report

On an annual basis, not later than ninety (90) days after the end of the RY, each hospital would be required to file with the Board an official Compliance Report.

- The Compliance Report would be accompanied by detailed supplemental data showing the volume of IP and OP services, the private sector payments and the payments that would have been made by Medicare for the patients covered by this legislation, on an MS DRG-specific basis for IP patients and on a CPT/HCPCS basis for outpatients, with all applicable modifiers, as described above regarding the BY Report. The Compliance Report would be required to be submitted, in an electronic format prescribed by the Board, not later than ninety (90) days after the end of the particular RY. The Board would be entitled to initiate audits of the Compliance Reports, to be conducted by independent audit firms selected by the Board, with the fees for such audits to be paid by the hospitals undergoing such audits to the Board for use by the Board for the compensation of the audit firms.

c) Certification of Compliance Report

Two senior administrative officials of each hospital (e.g., the CEO and the Senior VP of Finance or equivalent official) would be required to sign and certify, under the pains and penalties of perjury, that the information provided in the Compliance Report is, to the best of their reasonable knowledge and belief, accurate and fair in all of its representations. These officials would also be subject to any other penalties or sanctions established by the Board.

10. Hospital Pricing Compliance and Enforcement

Any amount of payments made by private sector patients above or below the payments that would have been made if the hospital's rates had been set at its prescribed Medicare payment ratio in any particular RY would be deducted from or added to the private sector payments due to the hospital in the subsequent RY with an adjustment for interest equal to the U.S. CPI-U for the period. Hospitals whose private sector payments in any particular RY exceed its prescribed Medicare payment ratio by more than three (3) percent would be subject to the adjustment described above in this section plus a penalty of 150% of the excess payment amount.

The Board will establish limited rights of appeal by the hospitals. The legislation the Board and the Hospital Rate Control System shall prescribe that these appeal rights will be established by the Board and that the rate reviews, compliance determinations and penalties, technical methods, and other processes and actions taken by the Board will not be subject to judicial review.

11. Conclusions

Of course, the precise transitional schedule used by a state to phase into more a more reasonable level of hospital prices for the private insurance market, will depend on the magnitude of pricing in the most recent year and may involve a transition that lasts more than five years (as illustrated in our example). A rate setting agency should closely monitor the financial condition of hospitals and possibly provide additional funding to support lower priced and struggling hospitals, particularly smaller hospitals operating in rural and underserved areas of the state.

As noted, once a state transitions to a set of more reasonable base rates, and begins to regulate actual hospital prices per unit of service, it can apply other beneficial adjustments and programs, such as the use of a Volume Adjustment System, as described in section that follows.

B. Use of a Volume Adjustment System (VAS) for Private Insurer Regulated Rates

Because RBP Caps constitute a pure Fee-for-Service payment system, the state will be vulnerable to hospitals increasing the volume of services they provide to compensate for the lower unit rates. This dynamic, of how FFS payment systems provide windfall profits to hospitals that increase volumes, and how hospitals that lose volumes are saddled with unfunded fixed costs and thus generate debilitating losses, is described in detail in the following section. This section also introduces the concept of a Volume Adjustment System (VAS) which is a mechanism pioneered by the Maryland all-payer Rate Setting Commission in 1976 to counter these negative incentives of standard FFS payments systems.

1. Statement of the Problem

The relentless hyper-escalation in the costs of health care services in the U.S. in recent years is primarily due to the accumulation of market power by hospitals, over years of merger and consolidation activity, to increase their year over year negotiated price increases with private payers. However, hospital spending has also been driven by large and ongoing increases in the volume of health care services provided on a per capita basis. The health services literature supports the conclusion that hospital volumes—admissions, readmissions, outpatient visits, outpatient procedures, and diagnostic tests — exceed the levels required for high-quality, cost-effective care.^{33,34,35}

As discussed in Part 1 of this report, the provision of unnecessary, and low-value hospital services is an understandable response by hospitals to the counter-productive financial incentives

of Fee-for-Service (FFS) payment arrangements that predominate in the reimbursement methods of most private and governmental payers. In the case of hospitals, the financial incentives of FFS payment, along with the economics of hospital cost structures (specifically, their proportions of fixed versus variable costs), conspire to create strong financial rewards for hospitals to increase the number of hospital services they provide. At the same time these same factors financially penalize hospitals that manage care effectively or experience volume drops that are beyond their control.

For hospitals, the counterproductive incentives of FFS payment models derive from two of its basic features:

- First, under FFS payment hospitals are paid fixed payment rates each time they deliver an inpatient or outpatient service (i.e., a fixed payment per CAT scan or ER Visit or inpatient admission, etc.) and they are not paid unless they deliver those services; and
- Second, the fixed payment rates that hospitals are paid for additional services, produce marginal or incremental revenues that are much higher than the marginal or incremental costs hospitals incur in producing these services. This excess of marginal revenues over the marginal costs incurred in the provision of new services, provides the hospitals with increased cash flow and profits.

These features of the standard FFS-based hospital payment methods ensure that a hospital's profitability will increase when it increases its volume of services. The flip side of the volume-inducing nature of FFS payment methods is the financial discouragement FFS payment incentives provide to decrease hospital volumes of care. When hospitals, paid under FFS lose volume, they forfeit one hundred percent of the revenue associated with the lost volume, reducing their ability to fund their fixed costs, which remain in the hospital's cost structure. The continued presence of these unfunded fixed costs is what causes hospitals to lose money when volumes decline.

All hospitals have cost structures that include a substantial proportion of costs that are largely fixed — e.g., depreciation, interest, utilities, insurance, plant operations and maintenance, administration, financial services, 24-hour ER staffing, housekeeping, employed physicians and most residency programs.

Hospital fixed cost percentages vary from hospital to hospital and from service to service, but the Maryland hospital rate setting Commission, the Health Services Cost Review Commission (HSCRC) reasonably estimated that fixed costs for most medium to large hospitals (i.e., in

excess of 50-75 beds) average between to be 40% to 50% of hospital total costs.³⁶ The proportions of a hospital's fixed and variable costs are integral to the dynamic of how hospitals increase their net surpluses when volumes increase and how they generate net losses when volumes decline. The following sections describe these dynamics in detail and propose an adjustment to hospital rates, the "Volume Adjustment System" (VAS) that can ameliorate the financial incentives hospitals face to increase their volumes of care and eliminate the penalty hospital face under FFS payment when they reduce unnecessary and low-value care, or experience volume reductions due to a deterioration in their patient demographics.

2. Rationale for the Development of the HSCRC's Volume Adjustment System (VAS)

As noted in Part 1 of this report, the problem of hospitals increasing the volume of services provided year over year to enhance their annual revenues was first recognized by the HSCRC in the 1975-1976 period. The HSCRC was in the process of establishing its initial or "base year" regulated rates for all Maryland hospitals in period 1974 to 1976. Once these base rates were established, the HSCRC had the legal authority to control the growth of these rates by dictating how much the rates could grow from year to year through the approval of an annual inflation rate update.

When applying its regulated rate update each year, the HSCRC noticed the tendency of hospitals to increase their volume of services which resulted in the generation of hospital revenues far in excess of total predicted revenues given the HSCRC's allowed and often parsimonious annual rate updates. The HSCRC also noted that the more the agency tightened its approved rate update, the more hospitals increased their volumes of services (i.e., the hospitals "made it up on volume"). Thus, while the HSCRC could control the growth in its regulated unit rates, it was unable to control the aggregate amount of hospital spending. This dynamic significantly undermined the HSCRC's cost-containment capabilities.³⁷

In response, the HSCRC developed the VAS, which was designed to counter the incentives of FFS payment, that induce hospitals to increase the number of hospital services to patients in their service areas, unnecessarily. At the time, the HSCRC was equally concerned about the reverse situation where hospitals, particularly small and rural hospitals, experiencing population declines, mounted year over year losses. Thus, the HSCRC's VAS was structured to address both circumstances.

In the remainder of this section, we will discuss the fixed and variable nature of hospital costs and the impacts of volume changes on hospital profitability. We also describe a VAS that states

with hospital rate setting systems can implement that would significantly reduce the incentive for hospitals to grow volumes unnecessarily, while at the same time supporting hospitals financially when they lose volumes. For these examples we make use of the HSCRC's estimate that medium and large hospitals have costs that are 60% variable and 40% fixed with volume change. These figures approximate the original fixed and variable cost assumptions used by the HSCRC in the application of its VAS. However, as we will discuss, states can modify the fixed and variable cost factors applied in VAS to reflect the specific characteristics of their hospital delivery systems and to increase or decrease the incentives of the VAS for hospitals to control their volumes of services.

3. Illustration of How Hospitals Benefit from Volume Increases and Lose when Volumes Decline

Hospitals have two types of costs: fixed costs, which are largely fixed over short-term strategic planning time-horizons (i.e., one to three years) and variable costs, which go up and down depending on the number and acuity of patients treated during a year.^{vii} As discussed multiple times, hospitals that have high proportions of fixed costs and are paid on a FFS basis, benefit financially from volume increases and lose when volumes decrease. A simple example illustrates this overall dynamic:

vii Most academic studies attempting to quantify the proportions of hospital fixed and variable costs determine these proportions by means of regression analyses over relatively long periods of time (i.e., 5-10 years). These studies have generally quantified variable costs to account for as much as 80% of total costs (with fixed costs accounting for 20% of total costs). These regression results are not corroborated by Maryland hospital CFOs which generally estimate variable costs to be 50-60% of total costs. This difference likely reflects the different planning time horizon of hospital administrators, which is generally only one to three years. The difference in cost proportions also reflects the time frame used in the variable cost studies which look at how hospital costs varied over relatively long periods of time (e.g., over extremely long periods of time, say over 10 years, most all hospital costs can be considered "variable"). In our view, reliance on these regression-based studies to establish the fixed/variable proportions to be used in a Volume Adjustment System is faulty for at least two reasons. First, the studies that have been done are technically and conceptually weak because the data available for most of them were limited and because most hospitals, particularly non-profit entities, tend to redeploy cost savings into expenditures before the profits that result from volume increases can be captured as savings in accounting records. As MedPAC has concluded, non-profit hospital administrators in particular, lacking equity managers that demand a high return on equity, redeploy most surplus revenues by so-called "empire building" activities such as buying physician practices, building new facilities and spending money on activities that expand these administrators influence in the communities they serve. Second, the establishment of fixed/variable cost ratios based on cost function studies ignores the much bigger, and more important, policy question—namely, do we want to encourage (or be neutral toward) hospital volume increases, given the massive evidence that current utilization levels include large amounts of unnecessary care? Or do we want to actively discourage volume increases, with some exceptions, and encourage volume decreases?

In our Base Case scenario, we assume that a hospital has \$100 million in total costs. 40% of those costs (\$40 million) are fixed, and the remaining 60% (or \$60 million) are variable. The hospital treats and discharges 10,000 patients per year and is paid an average of \$10,500 per discharge, for a total of \$105 million in revenue and a 4.76% operating margin in the Base Year (i.e., \$5 million profit/\$105 million in revenue = 4.76%). Further, we assume that the hospital's actual fixed and variable costs are 40% and 60% of total costs, respectively. (See Table 4 below.)

Table 4: Base Case Scenario

Base Year Assumptions:	
Hospital Volume in Discharges	10,000
Average Payment per Discharge	\$10,500
Average Cost per Discharge	\$10,000
Fixed Cost Percentage	40.0%
Variable Cost Percentage	60.0%
 <u>Hospital Proforma Statement</u>	
	<u>Base Year</u>
Hospital Revenue	\$105,000,000
Fixed Costs	\$40,000,000
Variable Costs	\$60,000,000
Total Costs	\$100,000,000
Base Year Profit	<u>\$5,000,000</u> 4.76%

a) Illustration of a 10% Volume Increase on a Hospital Paid FFS with Fixed/Variable Costs Percentages of 40% and 60% Respectively, without a VAS

For this scenario, assume that our subject hospital engages in strategy of purchasing most of the primary care physician practices in its service area and induces these physicians to increase patient referrals to the hospital. We assume that this situation results in a 10% increase in the number of patients treated. In this scenario, as a result of the 10% increase in patient volumes the hospital's variable costs and revenues would also increase by 10%, (from \$60 million to \$66 million) while the hospital would also experience a dollar for dollar increase in its revenue associated with the 10% volume increase (i.e., hospital revenues increase by \$10.5 million from \$105 million to \$115.5 million). However, its total costs would only increase by 6% (from \$100 million to \$106 million) reflecting the increased Marginal Costs the hospital must incur to produce these incrementally new volumes. This scenario results in a positive margin of \$9.5 million relative to the Base Case (an increase in the hospital's profits of \$4.5 million) and a Year 1 profit

margin of 8.23%. This improvement in the hospital's financial situation is purely attributed to its increase in volumes (see Table 4).

Table 4a: Impact of a 10% Volume Increase in Year 1 from Base Year without a VAS

Year 1 Assumptions: Volume Increase without a VAS		
Volume (Discharges) 1,000 Disch Increase	11,000	
Average Payment per Discharge	\$10,500	
Average Cost per Discharge	\$10,000	
Fixed Cost Percentage	40.0%	
Variable Cost Percentage	60.0%	
 <u>Hospital Proforma Statement</u>		
	<u>Year 1</u>	
Hospital Revenue	\$115,500,000	
Fixed Costs	\$40,000,000	
Variable Costs	\$66,000,000	
Total Costs	\$106,000,000	
Profit	<u>\$9,500,000</u>	8.23%

This simple example illustrates the counterproductive incentives of FFS payment which provides huge rewards for hospitals that increase volumes, for any reason, whether these new hospital services are needed or not. This is precisely the dynamic which results in the gross overproduction of hospital care that is endemic to the U.S. hospital system.

Illustration of a 10% Decrease in Hospital Volumes Paid FFS with Actual Fixed and Variable Cost Percentages of 40% and 60% Respectively, without a VAS

As an alternative scenario, relative to our Base Case assumptions, we assume that instead of the hospital purchasing local Primary Care Physician practices, a physician-led Accountable Care Organization (ACO) begins operation in the hospital's service area. These physicians operate under shared savings-based incentives to reduce both the cost and the volume of hospital care and thus are motivated to manage hospital care more effectively. In this example, we assume that the ACO successfully reduces hospital volumes by 10%. In this circumstance the hospital's fixed costs would remain constant from the Base Case, at \$40 million, but its variable costs and revenues would decrease by 10% commensurate with the 10% volume decrease, to \$54 million and \$94.5 million respectively. This results in a large decline in the hospital's profit from \$5 million to \$500,000 and a reduced profit margin to only 0.5% in Year 1. Again, this change in the hospital's profitability (as illustrated in Table 4b below) is completely a function of the volume decline that it experienced, and specifically the loss of revenues sufficient to cover the fixed costs associated with its reduced volumes.

Table 4b: Impact of a 10% Volume Decrease in Year 1 from Base Year without a VAS

Year 1 Assumptions & Results: Without a VAS	
Volume (Discharges) Discharge Decrease	9,000
Average Payment per Discharge	\$10,500
Average Cost per Discharge	\$10,000
Fixed Cost Percentage	40.0%
Variable Cost Percentage	60.0%
 <u>Hospital Proforma Statement</u>	
	<u>Year 1</u>
Hospital Revenue	\$94,500,000
Fixed Costs	\$40,000,000
Variable Costs	\$54,000,000
Total Costs	\$94,000,000
Profit	<u>\$500,000</u> 0.5%

4. Rationale for the Establishment of a Volume Adjustment System (VAS)

To limit or reduce the volume of marginal or unnecessary hospital services, a state's regulated payment arrangements should have the legal authority to employ a "Volume Adjustment System," whereby:

- An increase in the volume of a hospital's services does not provide additional revenue that exceeds the marginal cost of producing the additional services; and
- A decrease in the volume of a hospital's services does not cut the hospital's revenue by more than the percentage of the hospital's costs that are variable—i.e., hospitals have the ability to reduce variable costs when volumes decline, but the hospital must be left with sufficient revenue to cover its remaining fixed costs.

Although the national Medicare hospital Inpatient and Outpatient Prospective Payment Systems (IPPS and OPPS) do not make use of a such a volume adjustment (which we believe was a decided policy mistake on the part of the Medicare program), most of state rate setting systems had volume adjustments that were designed to limit a hospital's incentive to increase its inpatient or outpatient service volumes. These systems included the all-payer hospital rate setting systems in Maryland, New Jersey, Massachusetts, Washington and the Hospital Experimental Payment program (HEP) in Rochester.

Although these systems covered all patients and all-payers, the use of a VAS could be applied to rate setting systems that just covered one payer category (i.e., the commercially insured),

as was the case for Connecticut when it operated a hospital rate system that applied only to private insurer rates.³⁸ We believe that any state-based hospital rate setting system should be given the legal authority to implement the methods that are described in this paper across the payers participating in the state's rate regulatory system, whether the rate system applies to all-payers or just a single payer category, such as private sector payers.

Our proposed volume adjustment mechanism recognizes the role of fixed costs in the dynamics of rate adjustments tied to volume increases or decreases. Under the VAS, hospital rates would be reduced in response to volume increases because the higher volumes would enable the hospitals to spread their fixed costs over a larger utilization base. Conversely, hospital rates would be increased in response to volume decreases because the lower volumes would require the hospital to spread their fixed costs over a smaller utilization base. These rate adjustments, are designed to prevent hospitals from generating windfall profits by unnecessarily raising volumes and at the same time enable hospitals to preserve financial stability if they were to lose volume.

Hospitals can, and as the health services literature argues should, decrease the use of low-value and unnecessary care by reducing unnecessary admissions, readmissions, ER Visits, lab tests or diagnostic tests. However, hospitals with declining service area populations, which is common in rural areas or underserved areas, often experience volume declines that are beyond their control. The application of a VAS in this instance can help ameliorate the negative financial incentives hospital face, by funding their fixed costs when patient volumes decline.

5. Illustration of a Proposed Volume Adjustment System

As noted, the essential idea of a VAS is to eliminate the Marginal Revenue (MR), generated by FFS payment, (i.e., the assumed \$10,500 payment per patient) in excess of Marginal Cost (MC) required to treat the patient (i.e., the assumed \$6,000 variable cost per patient – 60% of \$10,000). To implement a VAS, a rate setting agency would apply a Variable Adjustment Percentage (VAP) designed to remove this excess of Marginal Revenues generated, due to increased volumes, over the Marginal Costs required to produce those new incremental volumes. For the first set of illustrations, we devise a VAP that will precisely neutralize the financial incentives the hospital faces with regard to volume changes (i.e., a situation where volume changes do not increase or decrease the profitability the hospital generates in a year). This percentage would be referred to as the “Revenue Neutral” VAP.

a) Use of a VAP to Neutralize Hospital Incentives Regarding Volume Increases

For the first example of the application of a Revenue Neutral VAP, we start with the Base Case volume, payment and operating cost assumptions from the assumptions illustrated in Table 4 above. In this first example to illustrate the use of a volume neutral VAP (illustrated in Table 5a below), we use a VAP of -42.86% in the case of a 10% volume increase under FFS payment. This negative VAP adjustment is constructed to precisely remove all Marginal Revenue over Marginal Cost the hospital can earn given when paid FFS and volumes are increasing. This Revenue Neutral VAP is derived as follows:

The \$4,500 excess of incremental MR > MC per discharge (i.e., the \$10,500 incremental payment per discharge less the hospital's marginal cost of \$6,000 per discharge) divided by the incremental payment per discharge of \$10,500 = 42.86%

Thus, the application of a VAP of -42.86% (shown as a negative adjustment) will precisely remove the excess of MR over MC realized by the hospital when volumes increase. When applied to reduce this hospital's marginal revenues, the application of this VAP results in precisely the same level of hospital profitability that the hospital experienced in the base year (i.e., profitably of \$5 million or 4.76%) prior to its increase in volumes, thus completely neutralizing FFS incentives to unnecessarily increase volume. This result is illustrated in Table 5a below.

Table 5a: Impact on Hospital Profitability of a 10% Volume Increase with the Use of a VAS

Base Case		Year 1 (Assumed 10% Volume Increase)	
Base Year Assumptions:		Year 1 Assumptions: With a VAS	
Hospital Volume (Discharges)	10,000	Year 1 Discharges (increase by 1,000 or 10%)	11,000
Average Cost per Discharge	\$10,500	Average Cost per Discharge	\$10,500
Average Cost per Discharge	\$10,000	Average Cost per Discharge	\$10,000
Fixed Cost Percentage	40.0%	Fixed Cost Percentage	40.0%
Variable Cost Percentage	60.0%	Variable Cost Percentage	60.0%
		Variable Adjustment Percentage used	-42.86%
<u>Hospital Proforma Statement</u>		<u>Hospital Proforma Statement</u>	
	<u>Base Year</u>		<u>Year 1</u>
Hospital Revenue	\$105,000,000	Hospital Revenue	\$115,500,000
VAP	NA	Volume Adjustment Percentage (VAP)	-42.86% -\$4,500,000
Revenue after VAP	\$105,000,000	Revenue after VAP	\$111,000,000
Fixed Costs	\$40,000,000	Fixed Costs	\$40,000,000
Variable Costs	\$60,000,000	Variable Costs	\$66,000,000
Total Costs	\$100,000,000	Total Costs	\$106,000,000
Profit	\$5,000,000	Profit	\$5,000,000

No Change in Profitability Base Year to Year 1 even with a 10% Volume increase

Because of the VAS and application of the calculated Volume Neutral VAP, the hospital's overall profitability is unchanged from the Base Year scenario despite the volume increase, and the VAS has neutralized the counterproductive payment incentives that hospital face under FFS to unnecessarily increase volumes.

Conversely, a state could use a VAP of +42.86% in the case of a volume decrease to precisely restore funding for the hospital's fixed costs associated with the reduce patient volume. This scenario is shown in Table 5b below. The application of a +42.86% VAP in the case of a volume decrease, precisely funds the hospital's fixed costs when volumes decline. Again, in both cases these adjustments neutralize the hospital's incentives with respect to volume change.

One can see that in either scenario (i.e., Table 5a showing a 10% volume increase or Table 5b – shown below - illustrates a 10% volume decrease) the use of a VAS fully adjusts the hospital's revenues and causes the hospital's profitability to remain unchanged from the Base Case scenario at \$5 million per year. Given the current circumstance of extremely strong incentives under FFS payment to increase volumes unnecessarily, which leads to hospitals' chronic over-provision of low-value service, the VAS can be applied to actively discourage the provision of unnecessary hospital services and simultaneously encourage hospitals to manage care more effectively and invest in efforts to improve the population health of its patients. These were the results achieved in Maryland when the VAS was applied to hospital rates regulated by the HSCRC in the late 1970, 1980s and early 1990s. However, the incentives of the HSCRC's VAS were not as severe as the incentives hospital face to eliminate volumes under a Fixed HGB.

Table 5b: Impact on Hospital Profitability of a 10% Volume Decrease with the Use of a VAS

Base Case		Year 1 (Assumed 10% Volume Decrease)	
Base Year Assumptions:		Year 1 Assumptions: With a VAS	
Hospital Volume (Discharges)	10,000	Year 1 Discharges (increase by 1,000 or 10%)	9,000
Average Cost per Discharge	\$10,000	Average Cost per Discharge	\$10,500
Average Cost per Discharge	\$10,500	Average Cost per Discharge	\$10,000
Fixed Cost Percentage	40.0%	Fixed Cost Percentage	40.0%
Variable Cost Percentage	60.0%	Variable Cost Percentage	60.0%
		Variable Adjustment Percentage used	42.86%
<u>Hospital Proforma Statement</u>	<u>Base Year</u>	<u>Hospital Proforma Statement</u>	<u>Year 1</u>
Hospital Revenue	\$105,000,000	Hospital Revenue Charged	\$94,500,000
VAP	NA	Volume Adjustment	42.86%
Revenue after VAP	\$105,000,000	Revenue after VAP	\$99,000,000
Fixed Costs	\$40,000,000	Fixed Costs	\$40,000,000
Variable Costs	\$60,000,000	Variable Costs	\$54,000,000
Total Costs	\$100,000,000	Total Costs	\$94,000,000
Profit	<u>\$5,000,000</u>	Profit	<u>\$5,000,000</u>
No Change in Profitability Base Year to Year 1 even with a 10% Volume Decrease			

As discussed, a state rate setting agency can adjust the VAP used in the application of a VAS to apply stronger financial incentives for the hospital to reduce low-value and unnecessary utilization. We illustrate such a scenario in this section.

In the previous section we described the use of a VAS and an associated VAP that would precisely neutralize hospital incentives regarding volume changes. However, the VAS gives rate setting agencies flexibility to adjust the magnitude of the VAP to either strengthen or reduce the incentives to constrain volumes. These results are illustrated in Tables 6a and 6b below, which assume the use of a larger VAP (a VAP of -60% for volume increases and +60% for volume decreases). Table 6a illustrates the use of a more aggressive VAP will cause the hospital to have a smaller profit, relative to its Base Case, when volumes increase (i.e., a volume increase of 1,000 CMADs with a VAP of -60% will reduce profits \$1.8 million from \$5 million in the Base Year, to \$3.2 million in Year 1).

Table 6a: Use of a VAP that Creates Stronger Incentives for Volume Reductions

Base Case		Year 1 (Assumed 10% Volume Increase)		10.00%
Base Year Assumptions:		Year 1 Assumptions: With a VAS		
Hospital Volume in Discharges	10,000	Year 1 Discharges (Increase by 1,000 or 10%)		11,000
Average Payment per Discharge	\$10,500	Average Cost per Discharge		\$10,500
Average Cost per Discharge	\$10,000	Average Cost per Discharge		\$10,000
Fixed Cost Percentage	40.0%	Fixed Cost Percentage		40.0%
Variable Cost Percentage	60.0%	Variable Cost Percentage		60.0%
		Policy Established VAP		-60.0%
<u>Hospital Proforma Statement</u>		<u>Hospital Proforma Statement</u>		<u>Year 1</u>
Hospital Revenue	\$105,000,000	Hospital Revenue		\$115,500,000
VAP	NA	Volume Adjustment	-60.0%	-\$6,300,000
Revenue after VAP	\$105,000,000	Revenue after VAP		\$109,200,000
Fixed Costs	\$40,000,000	Fixed Costs		\$40,000,000
Variable Costs	\$60,000,000	Variable Costs		\$66,000,000
Total Costs	\$100,000,000	Total Costs		\$106,000,000
Profit	<u>\$5,000,000</u>	Profit		<u>\$3,200,000</u>

Conversely, as shown below in Table 6b, if the hospital is successful in reducing unnecessary hospital care (or volumes naturally decline due to changing patient demographics) the hospital's profits will increase from \$5 million in the Base Year to \$6.8 million in Year 1, rewarding the hospital substantially for its improved volume control efforts.

Table 6b: Use of a VAP that Provides Stronger Financial Support for Hospital that are Losing Volume

Base Case		Year 1 (Assumed 10% Volume Decrease)		-10.00%
Base Year Assumptions:		Year 1 Assumptions: With a VAS		
Hospital Volume in Discharges	10,000	Year 1 Discharges (Decrease by 1,000 or 10%)		9,000
Average Payment per Discharge	\$10,500	Average Cost per Discharge		\$10,500
Average Cost per Discharge	\$10,000	Average Cost per Discharge		\$10,000
Fixed Cost Percentage	40.0%	Fixed Cost Percentage		40.0%
Variable Cost Percentage	60.0%	Variable Cost Percentage		60.0%
		Policy Established VAP		60.0%
<u>Hospital Proforma Statement</u>		<u>Hospital Proforma Statement</u>		<u>Year 1</u>
Hospital Revenue	\$105,000,000	Hospital Revenue		\$94,500,000
VAP	NA	Volume Adjustment	-60.0%	\$6,300,000
Revenue after VAP	\$105,000,000	Revenue after VAP		\$100,800,000
Fixed Costs	\$40,000,000	Fixed Costs		\$40,000,000
Variable Costs	\$60,000,000	Variable Costs		\$54,000,000
Total Costs	\$100,000,000	Total Costs		\$94,000,000
Profit	<u>\$5,000,000</u>	Profit		<u>\$6,800,000</u>

These examples show the use of a larger VAP (i.e., a VAP of +/-60%) strongly incentivizes the hospital to reduce unnecessary services and at the same time will support hospitals that are losing patient volume due to better care management or changing service area demographics. As noted, the exact magnitude of the VAP used by the rate setting agency is discretionary, depending on whether the agency wishes to apply stronger or weaker incentives for hospitals to manage the volume of care it provides patients in the hospital service area. However, it is important to note that as the VAP used in the VAS approaches +/- 100%, it may encourage hospital managers, who are not generally very sophisticated in the most productive ways to manage hospital care to reduce volumes by any means possible. As experienced in Maryland and various OECD countries this could result in overt attempts by hospitals to stint on and restrict care, or shift care out of the regulated hospital budget, in order to generate budget surpluses. As discussed in Part 1 of this report, we do not advocate the use of fixed budget incentives. We merely wish to illustrate the range of options available to states making use of a VAS.

c) The Incentives of “Flexible” HGBs vs. Incentives of Fixed HGBs

The use of a VAS and VAP, as described above, create what we have referred in other articles to as a “Flexible” HGB, a payment structure with incentives that are mid-way between the incentives of a FFS payment system and a Fixed HGB. As discussed, the use of a VAS and associated VAP was a mainstay of the early Maryland hospital rate setting system after it realized that hospitals would respond to “tight” annual hospital rate updates by dramatically increasing volumes. The power of this VAS in preventing the provision of unnecessary hospital volumes

was revealed later in Maryland when in 2000 HSCRC mistakenly eliminated this system. Facing extremely tight annual HSCRC rate updates in the years following 2000 due to concerns about the state possibly failing its Medicare Waiver payment per case growth test, hospital volumes exploded, increasing in excess of 2% in the years immediately after 2000.³⁹ Once again, the hospitals “made it up on volume.”

In short, the use of the VAS in Maryland in the period 1976-1992, was very successful in reducing excessive growth in hospital spending by greatly curtailing the hospitals’ tendency to increase low-value and unnecessary volumes of care, enabling the HSCRC to meet both its targeted growth overall hospital prices and hospital payments per capita.⁴⁰ As noted, this methodology also worked to maintain hospital revenues at levels sufficient to cover fixed costs should volumes decline.

d) Simulation Results for FFS, Flexible and Fixed Global Budgets with Volume Changes

Table 7 below provides a summary of the profitability results of our subject hospital under our three different bases of payment, Fee-for-Service, a Flexible HGB using a VAS with different VAP magnitudes and a Fixed HGB. It illustrates the results of both extreme scenarios, Column A showing the results of volume change under a pure FFS payment system and Column C under a Fixed Global Budget. As would be expected, relative to the Base Case, the hospital’s profitability improves considerably when paid FFS while experiencing a 10% volume increase (see Column A, line 6) and deteriorates significantly with a 10% volume decrease (see Column A, line 12). Conversely, if the hospital operated under a Fixed Budget (Column C) it would experience a large decline in profitability, from \$5 million in the Base Case to -\$1 million with a 10% volume increase (Column C, Line 6) and a huge increase in profits to \$11 million, in the event of a 10% volume decline (Column C, Line 12) under a Fixed Budget.

Columns B1, B2 and B3 show the how the hospital’s profitability changes with the application of a VAS using different VAP magnitudes. This ranges from the use of a “weak” VAP of +/-30% (which has only moderate impacts on profits with either a 10% increase or decrease in volume – see Column B1, lines 6 and 12), to a VAP using a “Revenue Neutral” VAP of +/-42.86% (which makes the hospital agnostic regarding volume changes – resulting in profits of \$5 million for either a 10% increase or 10% decrease in hospital volumes – see Column B2, lines 6 and 12) and finally to an application of a “strong” VAP of +/-60% which only modestly reduces the hospital’s profits to \$3.2 million with a 10% volume increase, but provides large rewards to the hospital with an increased profits of \$6.8 million when volumes decline by 10% (see Column B3, lines 6 and 12). This last scenario is instructive because it shows the difference in financial incentives

the hospital faces under a Fixed Budget when volumes decline by 10%, which allows the hospital to generate \$11 million in profits for reducing, restricting or shifting hospital volumes, compared to a profit of \$6.8 million when operating under a VAS with a “strong” VAP of +/- 60%.^{viii}

Table 7: Hospital Financials Under 3 Bases of Payment with a +/-10% Change in Volume^{ix}

A Volume Adjustment System with Different VAP Adjustments							
		A (2)	B1 (3)	B2 (4)	B3 (5)	C (6)	
		Base Case (1)	Volumes +10% FFS Payment = an Effective VAP = 0%	Volumes +10% VAS with a Weak VAP = 30%	Volumes +10% VAS with a Volume Neutral VAP=42.86%	Volumes +10% VAS with a Strong VAP = 60%	Volumes +10% Fixed HGBs with an Effective VAP = 100%
10% Volume Increase							
Volumes (discharges)	1	10,000	11,000	11,000	11,000	11,000	11,000
Total Revenues	2	\$105,000,000	\$115,500,000	\$115,500,000	\$115,500,000	\$115,500,000	\$115,500,000
VAP Offset to Revenues	3	NA	NA	-\$3,150,000	-\$4,500,000	-\$6,300,000	-\$10,500,000
Revenues after VAP	4	\$105,000,000	\$115,500,000	\$112,350,000	\$111,000,000	\$109,200,000	\$105,000,000
Total Costs	5	\$100,000,000	\$106,000,000	\$106,000,000	\$106,000,000	\$106,000,000	\$106,000,000
Profitability	6	\$5,000,000	\$9,500,000	\$6,350,000	\$5,000,000	\$3,200,000	-\$1,000,000
10% Volume Decrease							
Volumes (discharges)	7	10,000	9,000	9,000	9,000	9,000	9,000
Total Revenues	8	\$105,000,000	\$94,500,000	\$94,500,000	\$94,500,000	\$94,500,000	\$94,500,000
VAP Addition to Revenue	9	NA	NA	\$3,150,000	\$4,500,000	\$6,300,000	\$10,500,000
Revenues after VAP	10	\$105,000,000	\$94,500,000	\$97,650,000	\$99,000,000	\$100,800,000	\$105,000,000
Total Costs	11	\$100,000,000	\$94,000,000	\$94,000,000	\$94,000,000	\$94,000,000	\$94,000,000
Profitability	12	\$5,000,000	\$500,000	\$3,650,000	\$5,000,000	\$6,800,000	\$11,000,000
		See Table 1	See Tables 2a and 2b		See Tables 3a and 3b	See Tables 4a and 4b	

We are recommending that states consider using a VAS with a stronger VAP to instill relatively but not excessively stronger incentives (as is the case under Fixed Budgets) for a hospital to focus efforts on reducing unnecessary care. Again, based on the experience in Maryland and other developed countries making use of Fixed Budgets, we are fearful that the Fixed Budget incentives are disproportionately strong and will induce hospitals to be complacent about their care delivery and possibly stint on care or actively shift care to other providers.

^{viii} As noted previously, the use of a +/- 100% VAP would provide a hospital with precisely the same incentives of a fixed budget.

^{ix} Notes: (1) Base Case Scenario before Volume Change or application of a VAS; (2) Fee-for-Service (FFS) payment w/o a VAS; (3) Application of a VAS with a “weak” VAP +/-30%; (4) Application of a “Revenue Neutral” VAP of +/-42.86% (which neutralizes hospital incentives with regard to volume change; and (5) the Impact of a Fixed HGB (or an effective VAP= +/-100%)

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The Source on Healthcare Price & Competition ("[The Source](#)") works to address failing health care markets by providing up-to-date and easily accessible information about healthcare markets in the United States to a diverse array of stakeholder perspectives. The Source aims to bridge the gaps between health policy, law, and economics through its curated repository of news articles, policy papers, academic articles, litigation documents, and legislative/regulatory materials. Through analysis of these materials, The Source develops evidence-based policy solutions that promote healthcare affordability, access, equity, and quality to serve as a catalyst for change within the U.S. healthcare system.

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