

Commercial Healthcare Prices Working Group

October 27, 2026

Today's Objectives

- Provide a status update on the working group's progress and emerging focus on hospital price growth
- Hear how other states have addressed commercial hospital price growth and what lessons may apply to Minnesota
- Explore key policy design questions, including the scope, target, and structure of a potential Minnesota price growth policy

Today's Agenda

- **Welcome and Introduction – CHCA**
- **Working Group Status Update – CHCA**
- **How Other States Are Addressing Hospital Price Growth – Bailit Health**
- **Break**
- **Facilitated Discussion: Policy Design Considerations for Minnesota – Mathematica**
- **Closing and Next Steps – CHCA**

Key Takeaways from September Meeting

- Emerging support for **hospital price growth** as the primary organizing focus
- Concern about focusing on price alone, noting the need to consider **value and outcomes** in addition to price
- Emphasis on the need to understand the relationship between **hospital price growth, inflation, and costs of doing business**
- Recommendation for the state to **define a goal** for how much hospital prices should grow to measure the success of any growth-focused policy
- Request for additional and updated **data** from HEP, if possible

Working Group Roadmap

- **Meeting #1 (September 11):** Established shared understanding of hospital price levels, variation, and drivers; reviewed state policy approaches
- **Meeting #2 (October 27, Today):** Deep dive into state approaches to addressing commercial hospital price growth; facilitated discussion on policy design questions
- **Meeting #3 (December 2):** Evaluate policy options and recommend approaches for consideration to the Health Care Affordability Advisory Task Force (HCAATF)

Questions for Discussion 1

- What questions do you have about the key takeaways from the September meeting and the working group roadmap?



How Other States Are Addressing Hospital Price Growth

Commercial Healthcare Prices Working Group

October 27, 2026

bailit health

Agenda

1. State Strategies for Managing Hospital Prices and Their Growth
2. Discussion

STATE STRATEGIES FOR MANAGING HOSPITAL PRICES AND PRICE GROWTH

States Have a Range Options When it Comes to Commercial Hospital Price Growth Mitigation (1 of 2)

- **Hospital Price Cap:** Limits hospital payments to a specified level.
- **Hospital Price Growth Cap:** Limits how much hospital prices can grow each year.
- **Hospital Global Budget:** Provides an annual fixed budget to hospitals for a set of defined services.
- **Site-Neutral Payment:** Eliminates the price differential for certain outpatient services delivered within hospital-owned settings and other lower-cost settings.
- **Facility Fee Ban:** Bans additional fees for certain outpatient services delivered within hospital-owned settings.

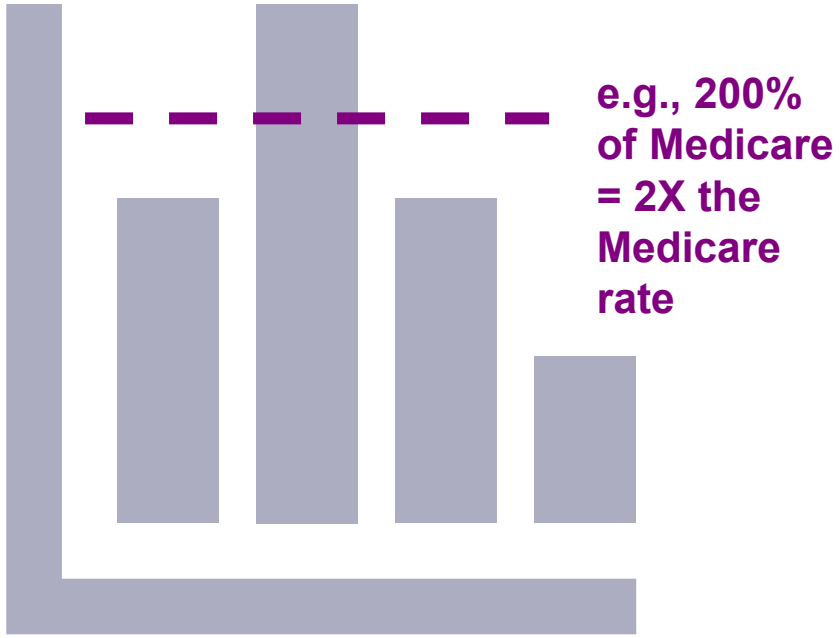
States Have a Range Options When it Comes to Commercial Hospital Price Growth Mitigation (2 of 2)

- **Transparency:** Public reports on comparative hospital prices and their growth.
- **Market oversight**: CON and CMIR approvals with linked price growth caps
- **Prohibition of anti-competitive practices**: Seven specific prohibitions on provider/insurer contract language that can serve to inflate health care spending

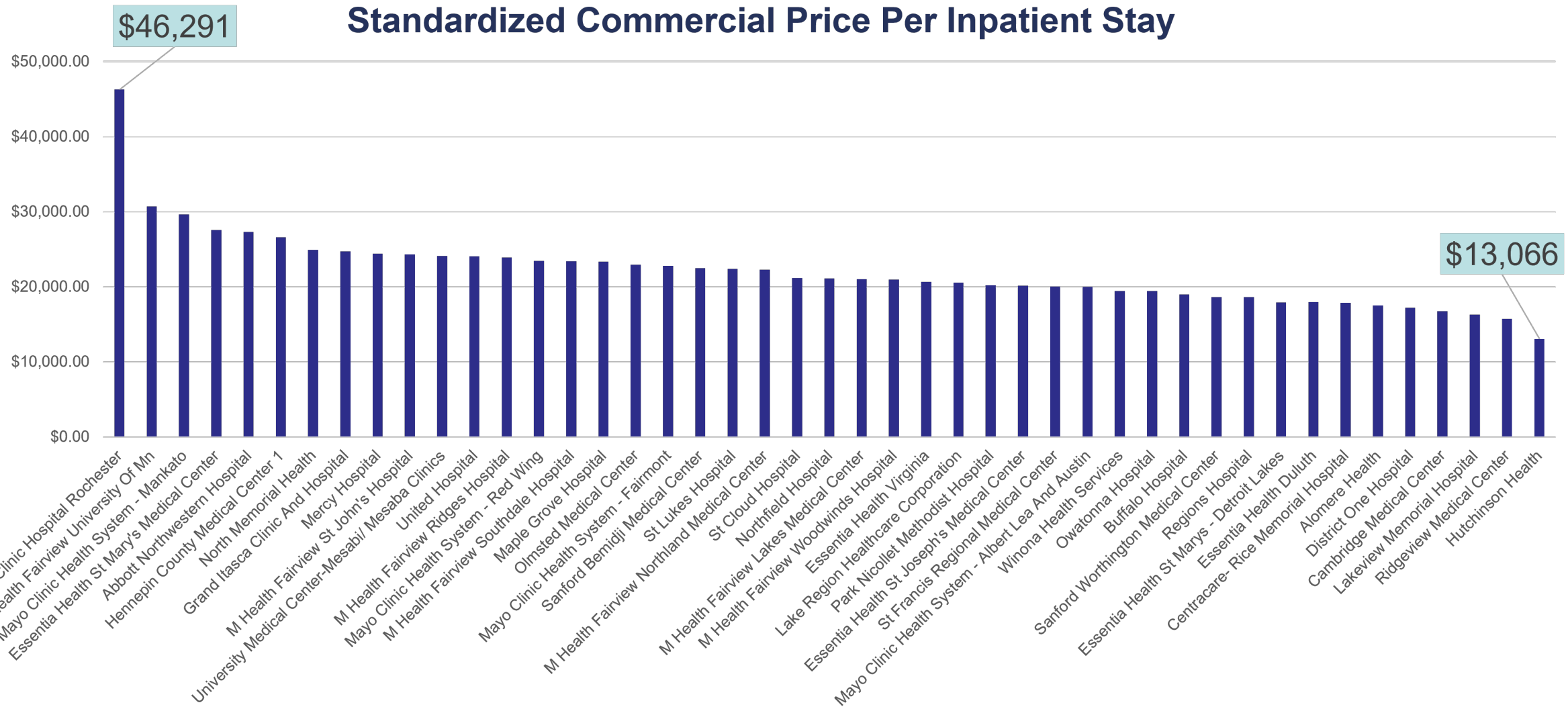
#1: HOSPITAL PRICE CAP

What is a Hospital Price Cap?

- A hospital price cap, also referred to as “reference-based pricing”, limits the payment amounts for hospital services.
  - These limits are established in reference to an external payment benchmark, usually a percentage of Medicare.
  - Limits apply directly to the prices hospitals can charge, or to health plans’ contracted reimbursement amounts.



Commercial Prices at Minnesota Hospitals



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

Hospital Price Cap: State Options

States have three options for implementing a price cap:

1. **State purchasing authority:** The state caps prices for care purchased through public programs (e.g., the state employee health plan).
2. **Insurance regulation:** The state regulates maximum reimbursement rates for services covered by fully insured private plans.
3. **Provider price regulation:** The state limits prices providers can charge.

Price Cap Impacts

- **Lowers the overall cost of providing insurance** for employers and enrollees.
  - Oregon evaluations have found significant savings (see next slides); Montana's prior price cap program in the state employee health plan generated an estimated $47.8 million in state savings over three years.
- **Curbs premium growth** for employers and enrollees.
  - Lower prices for hospital services should be accounted for in medical trend calculations that impact premium amounts.
  - Vermont's legislation explicitly requires that savings are passed on to consumers.
- **Reduces cost-sharing** obligations for members who use hospital services.
  - Since some out-of-pocket costs for hospital services are based on a percentage of the allowed amount for the service, lowering paid amounts lowers member cost-sharing.
  - Curbing hospital spending growth can also help protect against the need for employers to further shift costs onto consumers through higher cost-sharing.

Price Cap: Oregon (1 of 2)

- Oregon implemented a price cap for its state and school-based employee health plans in 2019. The price cap was mandated through legislation, giving it durability.
  - Services: All inpatient and outpatient facility services (not professional).
  - Cap level: 200% of Medicare; out-of-network cap of 185% of Medicare to discourage providers from leaving plan networks.
  - Exemptions: Oregon exempted small, rural, critical access, and certain sole community hospitals to protect the financial stability of vulnerable facilities and maintain network participation. As a result, the cap applies to 24 of 62 hospitals in the state, but they represent the majority of spending.
- Requirements are included in contracts with public employee health plan carriers. Carriers must pay the lesser of current rates and the price cap to protect against a run up to the cap.

Price Cap: Oregon (2 of 2)

- Measurement:
  - Oregon has historically annually evaluated compliance in aggregate, and not at the service level, meaning that some services could have price increases above the cap.
  - Oregon is considering changing this approach to assess compliance at the service level.
- Enforcement:
  - If the aggregate payments exceed the cap level, the carrier or TPA must pay the difference to the State.
  - Any payments returned by the TPA are deposited into the Public Employees' Revolving Fund or Oregon Educators Revolving Fund, which can be used to pay premiums, stabilize premiums, etc. Any payments returned by a fully insured carrier will be "a credit to fully-insured premium rates equivalent to this difference."

Price Cap: Oregon Impact

The cap was estimated to save $113M in 2021 (7% of total spending).

- Researchers subsequently found no evidence of hospitals leaving state employee health plan networks or increasing prices to other commercial health plans.
- Individuals in high cost-sharing plans experienced a 9.5% reduction in out-of-pocket spending per outpatient procedure as a result of the price cap.

Rakotoniaina A. Oregon Saves Millions Using Reference-Based Pricing. NASHP. Marsh 23, 2023.
Murray RC, et al. Hospital Facility Prices Declined as a Result of Oregon's Hospital Payment Cap. *Health Affairs*. 2024;43(3):424-32.

State Momentum on Hospital Price Caps

State	Market and Policy Lever	Statutory Dates
Oregon	State and school-based employee health plans • 200% of Medicare for in-network and 185% for out-of-network	2019 - present
New Mexico	State employee health plan; expanded to school-based health plans effective July 2026 • 200% of Medicare for in-network and 175% for out-of-network	July 2025 - present
Vermont	Commercial market-wide • Cap level TBD • Price cap will apply to the entire commercial market (self- and fully insured) via provider-side regulation.	beginning Oct. 2026 (delayed)
Washington	State and school-based employee health plans • 200% of Medicare for in-network and 185% for out-of-network • Aggregate statewide hospital price caps at 160% of Medicare rates in its public option program since 2021	beginning Jan. 2027
Indiana	Commercial market-wide • Price cap will be set based on statewide average payment rates for inpatient and outpatient services. • Applies to the entire commercial market (self- and fully insured) via provider-side regulation.	beginning July 2029

#2: PRICE GROWTH CAP

Overview of Hospital Price Growth Cap

- A price growth cap limits how much provider payments can grow each year; the cap can be linked to an economic indicator such as Consumer Price Index (CPI) or gross state product (GSP) growth.
  - It can be applied to all hospitals, or to certain classes of hospitals where price growth has been problematic.
  - It can be applied differentially based on relative baseline prices.
  - It can be applied to each provider contract individually or across all of a given payer's contracted providers.
  - It is usually implemented and enforced through insurance regulation.
- State examples: California, Connecticut, Delaware & Rhode Island

Price Growth Cap: Rhode Island (1 of 2)

- In 2010, Rhode Island's Office of the Health Insurance Commissioner implemented "Affordability Standards" for all commercial insurers in the state.
- Among other requirements, the standards limit the average annual payment increases for both inpatient and outpatient hospital services within each insurer-provider contract.
  - Current hospital price growth cap level: CPI +1%
- Other design details:
  - All hospitals with no exceptions, although the lowest-price hospitals received a one-year price bump several years ago
  - Fully insured commercial market, but spillover effect to the self-insured

Price Growth Cap: Rhode Island (2 of 2)

- Measurement:
  - RI reviews insurer rate filing assumptions for hospital price increases against the price growth cap to assess compliance.
  - RI requires submission of a provider reimbursement template on historical and projected rate changes by hospital.
  - RI conducts periodic market conduct exams, reviewing insurer hospital contracts to assess compliance with the growth cap.
    - Measurement is usually easy because contracts specify rate increases as a percentage, but sometimes more complex calculations are necessary, e.g., when drug prices are specified as a percentage of Average Sale Price (ASP).
- Enforcement:
  - Insurers found to be in non-compliance can have their rate requests rejected. They are also subject to financial penalties.

Price Growth Cap: Rhode Island Impact (1 of 3)

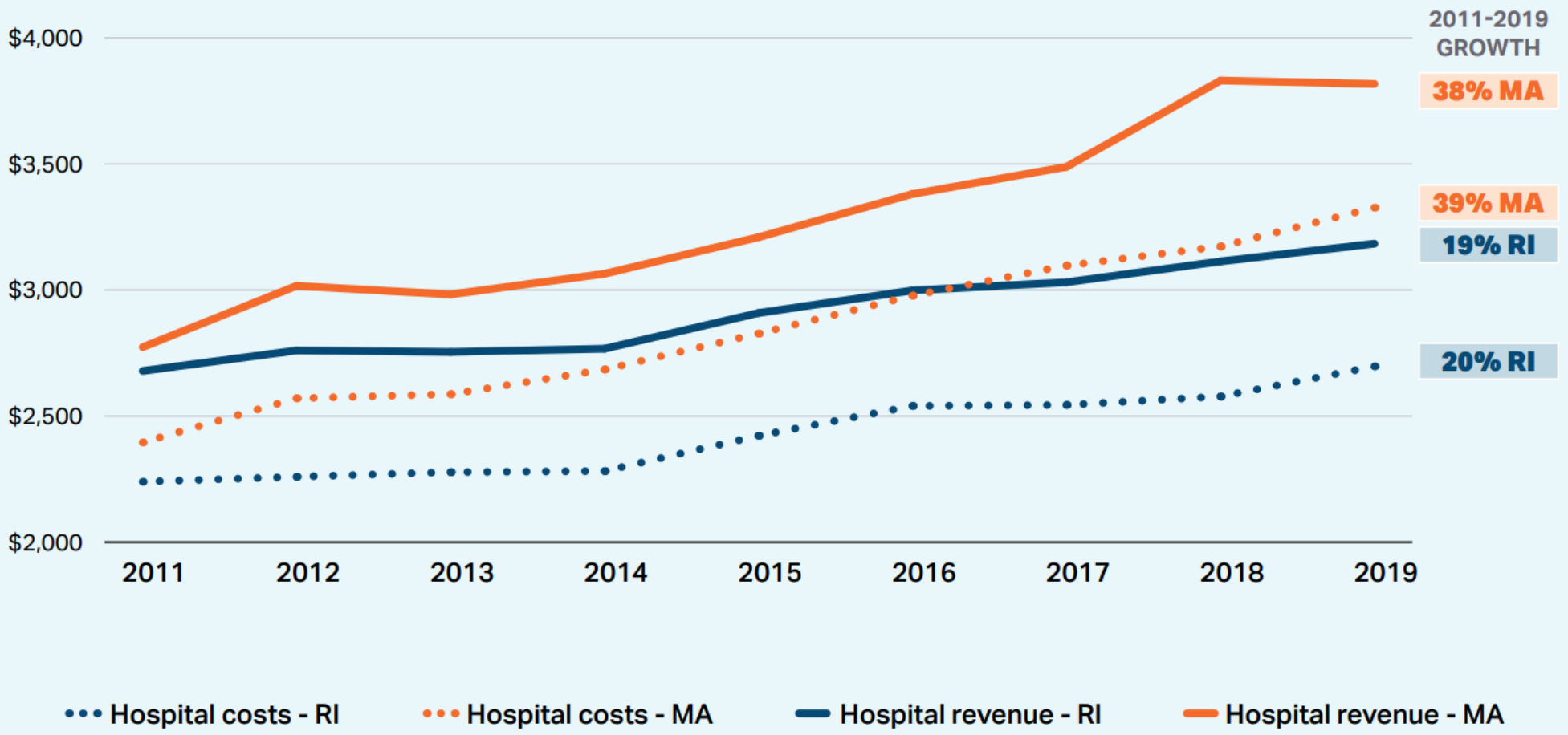
- A 2025 study found that the Affordability Standards resulted in an average of **$87.7M in *annual* savings**; $64.1M of this accrued to employers, while $23.7M accrued to plan members in the form of premium and out-of-pocket cost savings.
  - The study found that hospital prices decreased by 9.1% on average from 2012-2022 (vs. comparison states) and a 19% reduction in premiums by 2022.
  - After two years of implementation, Rhode Island hospital prices were above the national average (106% in 2012); by the end of the study period, they were below the national average (84% in 2022).

Price Growth Cap: Rhode Island Impact (2 of 3)

- An earlier published evaluation found that the Affordability Standards were associated with a **$55, or 5.8%, net decrease in quarterly total health care spending per commercially insured enrollee**, relative to a control population.
- The paper also found the cost growth cap to have had no impact on quality of care.

Price Growth Cap: Rhode Island Impact (3 of 3)

Exhibit 3.1. Growth in hospital prices and costs per capita in Rhode Island and Massachusetts, 2011-2019



Notes: Hospital costs shown are the portion of operating expenses related only to hospital patient care and eligible for reimbursement per Medicare federal regulations, sometimes referred to as Medicare Allowed Costs.

Sources: HPC analysis of hospital costs and revenues from NASHP hospital cost tool for the 2011-2019 period. Population data from the U.S. Census Bureau for 2011-2019 period.

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

#3: HOSPITAL GLOBAL BUDGET

What is a Hospital Global Budget?

A **fixed payment**, determined prospectively, that is based on historical utilization and adjusted annually based on changing demographics, market share and case mix

Current Hospital Payment Model

- Hospitals are **paid per unit of service**.
- Hospitals are compelled to **deliver more services**, and **higher margin services**, to maximize financial performance.

Hospital Global Budgets

- Hospitals receive a **budget** for a set of **defined services** that is determined **prospectively**.
- Budgets are based on **anticipated utilization** during a set time period.
- Budget **growth is limited over time**.
- Budgets can be **modified from year to year** based on changes in market share and other factors.

Why Consider a Hospital Global Budget?

- Hospital global budgets provide a mechanism to:
  - **Control growth** in hospital spending at an affordable level
  - Ensure **steady, predictable financing**, including but not limited to community hospitals in financial distress
  - Provide **greater flexibility** to modify hospital service offerings to best meet community needs
  - Produce **positive outcomes** without having adverse effects on hospital finances

State Implementation of Hospital Global Budgets (1 of 2)

- These four states have experimented with hospital global budgets:
  - NY Hospital Experimental Payment Program (1980 – 1987)
  - MD All-Payer Model and TCOC Model (2010 – 2025)
  - PA Rural Health Model (2019 – 2024)
  - VT All-Payer ACO Model (2018 - 2025)
- Each state's model has been unique and reflective of state-specific policies and market dynamics.

Pennsylvania	Maryland
• Focused on improving financial performance of small rural hospitals • Medicare, Medicaid managed care, and commercial payers participated • Ended in 2024	• Set prospective, all-payer hospital global budgets; used all-payer rate setting • Medicare participation has now transitioned into AHEAD Model

State Implementation of Hospital Global Budgets (2 of 2)

- CMMI's AHEAD Model launched in 2026 in Maryland. Connecticut, Hawaii, New York (selected counties), and Vermont were also accepted to participate, starting in 2028.
  - Vermont has since dropped out. CMMI is about to issue an opportunity for two additional states to join. Several are interested.
- Key AHEAD Model Components
  - Medicare participation in hospital global budgets. Participation from Medicaid and at least one commercial insurer required.
  - Enhanced primary care payments to participating primary care practices ($17-21 PMPM).
  - Participating states must meet targets for reducing growth in Medicare spending.

#4: SITE-NEUTRAL PAYMENT

Overview of Site-Neutral Payment

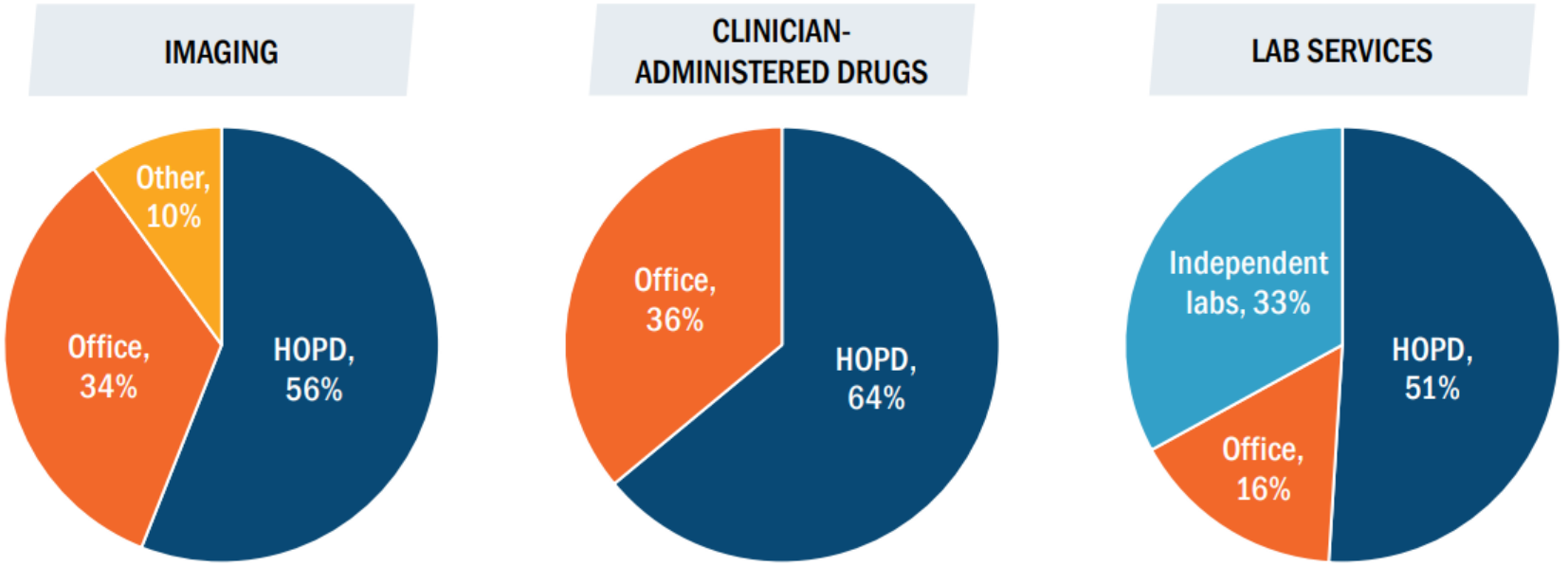
- Site-neutral payments aim to eliminate the price differentials (combined facility + professional charge) between outpatient services delivered within hospital-owned or affiliated settings and those that can be safely and appropriately provided in lower-cost settings, such as in an independent physician's office or another freestanding setting.
  1. Prohibit payments that exceed reference-based non-hospital rates for a defined set of outpatient services, typically capped at a percentage of Medicare's non-hospital rates.
     - Alternatives to capping rates include setting standardized rates or rate corridors with upper and lower payment limits.
  2. Limit the prices hospitals can charge, or limit health plans' contracted reimbursement amounts.

Services routinely provided across different care settings

Many common ambulatory care services are routinely provided across different settings of care.

HPC

Percentage of each service type provided in each setting, Massachusetts commercially-insured patients, 2021

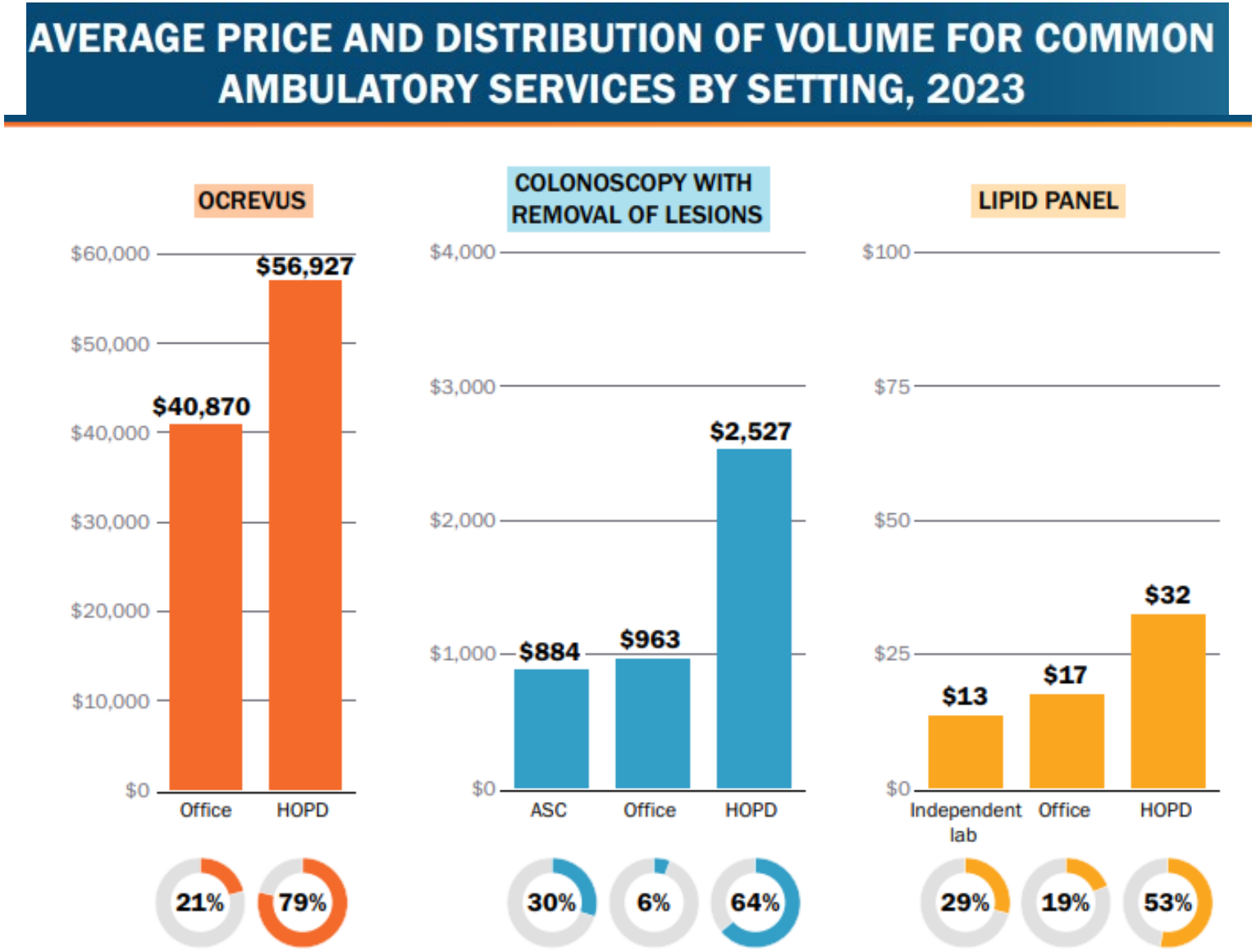


Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2021, V2021.

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Although these services are provided across many care settings, payers typically **pay more for the same services** when provided in hospital outpatient departments (and other facilities).

Price differentials for common ambulatory services



- For all three services examined, the price was much higher when the service was provided in a HOPD.
- HOPDs represented the setting of care with more than half of the volume for each service.

Source: HPC analysis of CHIA All-Payer Claims Database, 2023. Annual Health Care Cost Trends Report Chartpack (2025). Available at: https://masshpc.gov/sites/default/files/2025%20CTR%20Chartpack_1.pdf

Implications of Payment Differentials by Site of Care

- Due to the higher commercial prices in these settings, **consumers also typically pay more for the same services** when provided in hospital outpatient departments in the form higher out-of-pocket costs and in higher overall premiums.
- In addition to increasing spending by paying more than necessary to deliver care, this practice **encourages consolidation** of office-based practices into hospital-based health systems (vertical integration), to capture the higher payments and profits.

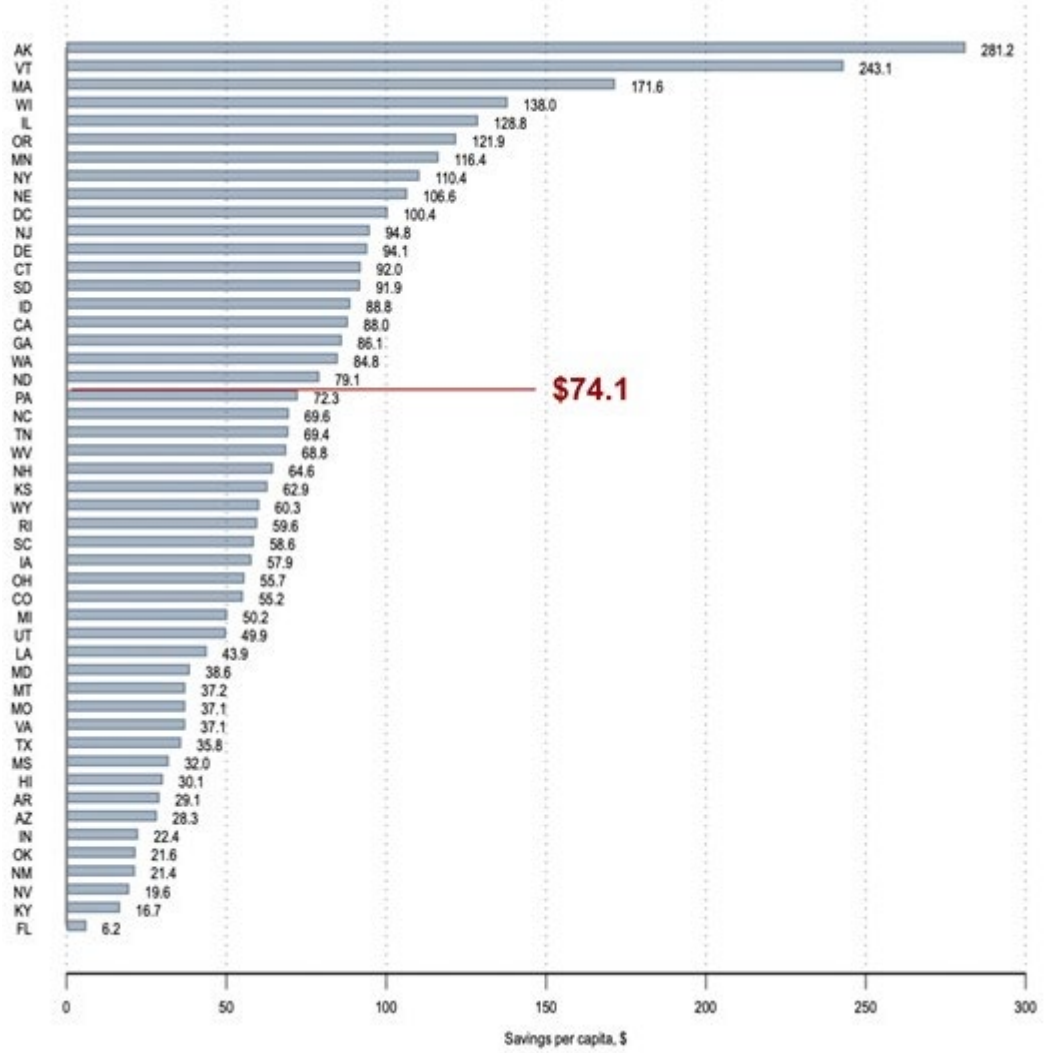
Site-Neutral Payment Impact

- **Lowers the overall cost of providing insurance** for employers and enrollees.
  - By focusing on outpatient services where additional payment is not justified, site-neutral payments directly address excessive prices while utilizing a more targeted approach than a commercial market-wide price cap.
  - Eliminates incentives to shift care to higher-cost hospital departments solely to maximize revenue.
- **Curbs premium growth** for employers and enrollees.
  - Lowers prices for some hospital services should be accounted for in medical trend calculations that impact premium amounts.
- **Reduces cost-sharing** obligations for members who use hospital services.
  - Since some out-of-pocket costs for hospital services are based on a percentage of the allowed amount for the service, lowering paid amounts lowers member cost-sharing.
- **Disrupts upstream incentives for further market consolidation**, which drives up prices without corresponding improvements in quality.

Modeling Projected Savings from Site-Neutral Payments

- A recent *Health Affairs* study found that implementing site-neutral payments for Minnesota commercial insurers by capping prices at **150% of Medicare** non-hospital payments would have saved purchasers and patients a **total of $263.4 million**.

Savings in millions, $ (Minnesota)					
150% cap	200% cap	250% cap	300% cap	350% cap	400% cap
$363.4	$233.7	$147.6	$102.7	$82.2	$68.0



Source: Roslyn C Murray, Haroon Janjua, Christopher M Whaley, Site-neutral payment for routine services could save commercial purchasers and patients billions, *Health Affairs Scholar*, Volume 3, Issue 12, December 2025. Available at: https://doi.org/10.1093/haschl/qxaf241.

Examples of Site-Neutral Payment Legislation

NY Fair Pricing Act (S705) and NASHP model legislation

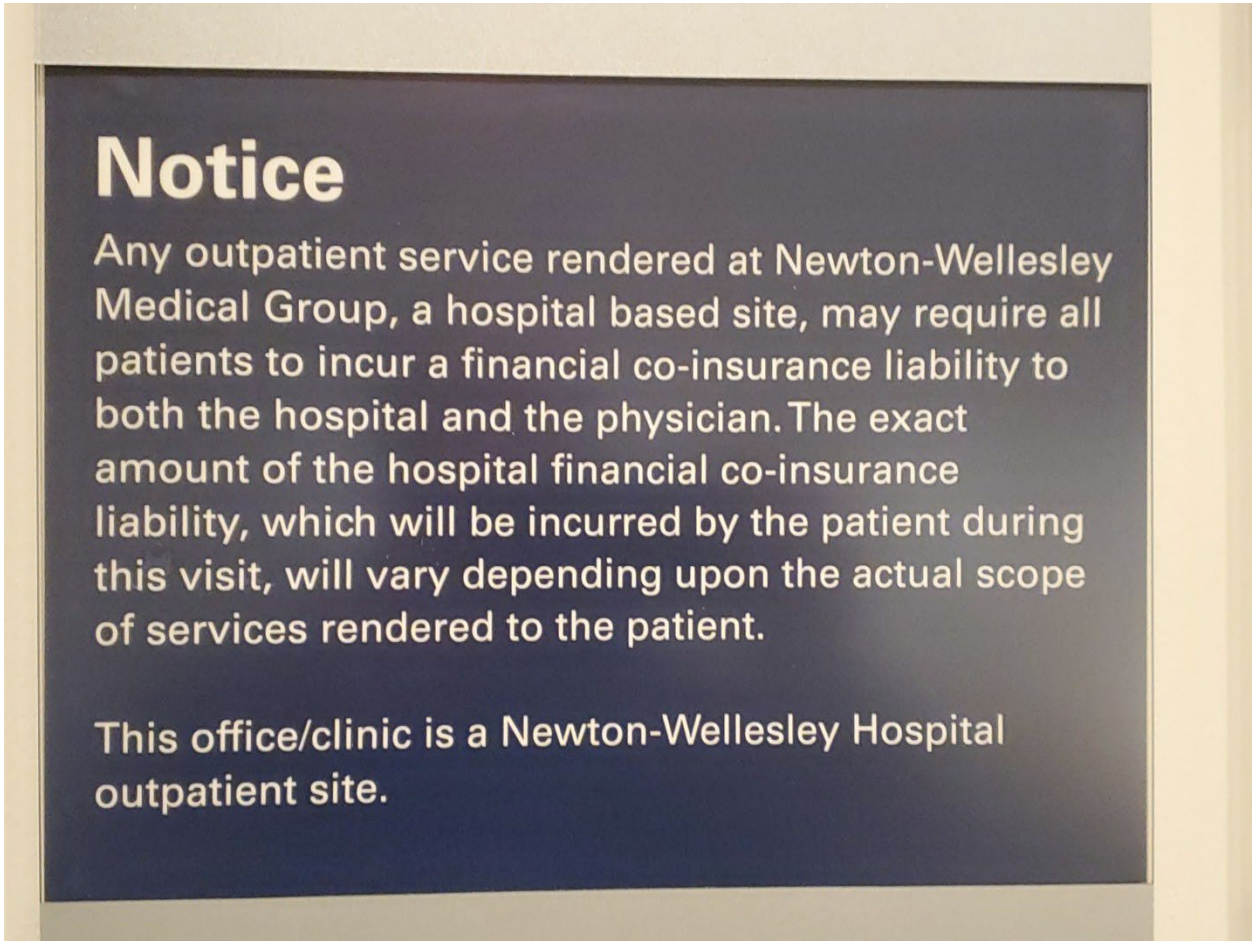
- *Provider-side regulation*: Prohibits providers from charging, billing, or accepting payment for applicable services that exceeds the lesser of a defined percentage of the Medicare non-hospital rate (150% in Fair Pricing Act) for the same service, or existing negotiated rate.
- *Applicable outpatient services*: 66 ambulatory payment classifications (APCs) identified by MedPAC's June 2023 Report to Congress as appropriate for site-neutral payment
  - Any additional outpatient services recommended or required to be paid in a site-neutral manner by MedPAC, or by federal or state law, which allows services to be added over time.
- *Hospitals and providers*: The Fair Pricing Act exempts public hospitals, critical access hospitals, sole community hospitals, rural emergency hospitals, safety net hospitals, and federally qualified health centers.

#5: FACILITY FEE BAN

Overview of Facility Fee Bans

- Facility fees are additional fees that hospitals and health systems charge for outpatient services at institution-owned sites of care, such as hospital outpatient departments and clinics. They are ostensibly intended to cover the operational costs of maintaining the facility.
- As hospitals acquire physician practices and shift services into hospital outpatient departments and other hospital-owned settings, hospitals often impose added facility fees for services that were previously billed at lower, office-based rates.

Facility Fees in Practice



Facility Fee Bans in Concept

- States can seek to ban outpatient facility fees, which entails prohibiting providers from charging or accepting payments for a facility fee for a professional service.
- Several states have banned facility fee charges in certain circumstances, although the scope of these laws varies significantly.

Minnesota law does not ban facility fees. Instead, it requires that hospital-based facilities notify consumers regarding facility fees in multiple formats and circumstances - including before care is provided and in signage at the facility - that they may receive a separate facility charge which may result in a higher out-of-pocket expense.

Facility Fee Ban: Connecticut (1 of 2)

- Effective 2023, Connecticut banned hospital-owned or -operated facilities located offsite from a hospital's main campus from charging facility fees for outpatient evaluation and management (E&M) or assessment and management (A&M) services.
- In 2024, this prohibition was extended to on-campus services, excluding EDs and certain observation stays. Connecticut also prohibits facility fee charges for any telehealth services.
- The statute regulates hospitals and therefore applies across all payer markets.
- Compliance is subject to Dept. of Public Health oversight.

Facility Fee Ban: Connecticut (2 of 2)

- The State additionally requires detailed hospital and health system reporting on facility fees, limits consumers' exposure to facility fee-related out-of-pocket costs, and requires various consumer disclosures regarding facility fee charges.

#6: PRICE TRANSPARENCY
#7: MARKET OVERSIGHT
#8: PROHIBITION OF ANTI-COMPETITIVE PRACTICES

Price Transparency

- RAND's analyses and many state-level APCD analyses have been used to make transparent
  - Hospital-specific commercial price levels
  - Commercial hospital price variation for one or more common services
  - Commercial hospital price growth
- Transparency can enhance understanding, but will not mitigate the impact of high and growing hospital prices.

Market Oversight

- Most states maintain Certificate of Need (CON) and Cost and Market Impact Review (CMIR) processes to regulate major delivery system capital investments (CON) and large mergers and acquisitions (CMIR).
- States can use these processes to stipulate price growth restraints as part of the conditions of approval.
  - Example: When the Massachusetts Attorney General approved the merger of the Beth Israel Deaconess and Lahey health systems, it required that for seven years following the merger, the new system would limit commercial price increases below the state's health care cost growth target (3.1% at the time).

In 2023, Governor Walz approved a bill (HF 402) that requires advance notice to the attorney general and commissioner of health of certain health care transactions and prohibits anticompetitive transactions.

Prohibition of Anti-Competitive Practices (1 of 3)

Many states have prohibited some or more of the following anti-competitive practices that have the effect of increasing prices:

1. **All-or-nothing clauses**: require that if a payer wants to contract with a particular provider in a health system, the payer must contract with *all* providers in that health system
2. **Anti-tiering clauses**: restrict a payer from creating a tiered network product, prevent a payer from putting a provider in a nonpreferred network tier, or require a payer to place all providers within a health system or provider entities in the same tier
3. **Anti-steering clauses**: bar a payer from using incentives and tools that encourage patients to use competing providers

Minnesota has no restrictions on all-or-nothing, anti-tiering or anti-steering contract clauses

Prohibition of Anti-Competitive Practices (2 of 3)

Many states have prohibited some or more of the following anti-competitive practices that have the effect of increasing prices:

4. **Exclusive contracting clauses**: bar a payer from including competing providers in their provider network
5. **Most-favored-nation clauses**: require a provider to give a payer the lowest rates of all contracted payers.
6. **Gag clauses**: restrict a payer, plan administrator, or provider from disclosing price or quality information in a contract agreement to government entities, patients, or other parties
7. **Non-compete clauses**: prevent an employee from taking a job with a competing provider or starting a new practice within a given distance for a given duration of time

Prohibition of Anti-Competitive Practices (3 of 3)

Minnesota policies:

- **Exclusive contracting clauses**: It does not appear that Minnesota prohibits exclusive contracting clauses.
- **Most-favored-nation clauses**: Minnesota bans most-favored-nation clauses in insurer-provider contracts, prohibiting guaranteed best rates or allowing contract changes if lower rates are offered elsewhere (Minn. Stat. § 62A.64).
- **Non-compete clauses**: In 2023, Minnesota became the fourth state to ban noncompete agreements, though the ban was not retroactive and still permits them in connection with the sale or dissolution of a business.
- **Gag clauses**: Minnesota prohibits gag clauses in specific circumstances: a) PBMs, insurers, pharmacies and pharmacists and b) how certain medical professionals can discuss the roles of non-licensed practitioners in treatments.

DISCUSSION

Questions for Discussion 2

- What aspects of the state approaches described do you think are most desirable for Minnesota, given what you know about the Minnesota market?
- What are the most significant design challenges or tradeoffs that Minnesota policymakers should be aware of?



Break

Policy Design Considerations for Minnesota

Julie Sonier| Mathematica

Overview of Policy Design Considerations

Today's Discussion

- Which hospitals should the policy apply to?
- Should the policy vary across different hospital types?
- Which patient populations should the policy apply to?
- Which services and sites of care should be included?
- What adjustments should be considered for special circumstances?

Future Discussion

- How should "prices" be defined, and what data would be needed to measure price growth?
- What would monitoring (and potentially enforcement) of a policy look like?

Scope: Which Hospital Categories Would a Policy Apply To?

The scope of state policies aimed at hospital price growth varies

States may choose to apply policies:

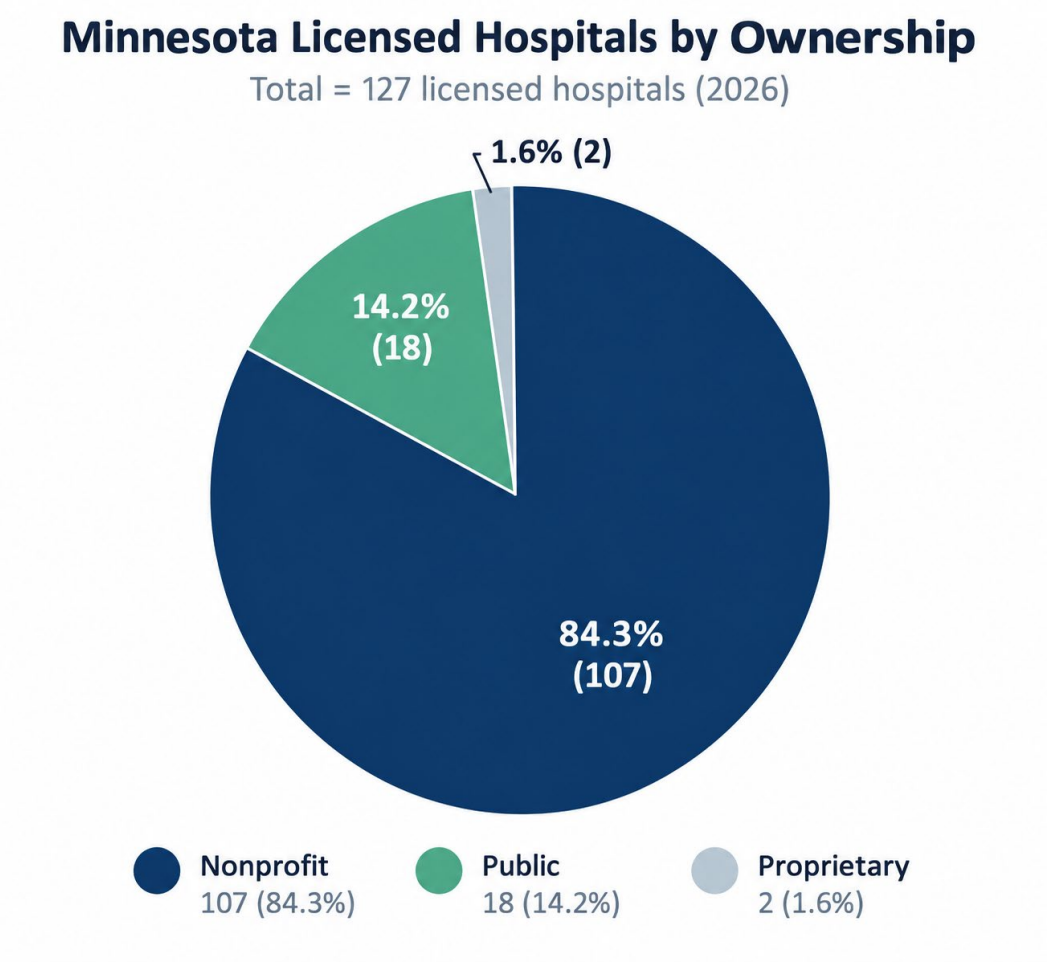
- **Broadly**
- **Exempt certain hospitals;** or
- **Set different specifications based on hospital characteristics**

Policy Examples Impacting Hospital Categories

State	Hospitals / Entities Included	Exemptions
Rhode Island	All Hospitals licensed in Rhode Island	
Delaware	Hospitals subject to commercial payer rate filings	Medicare-dependent rural and urban Medicaid DSH hospitals and approved multi-payer global budgets. Free standing children's hospitals also have their own formula
Oregon	Hospitals serving members of the state employee health plan	Small rural facilities, critical access hospitals, certain sole community hospitals, and out-of-state hospitals.
Indiana	Large non-profit hospital systems	

Minnesota Hospital Inventory

- State-licensed hospitals: **127**
  - Of which, **90** are rural acute care hospitals
    - Of which, about **76** are designated as critical access hospitals



Source: MDH; MDH

Scope: Which Patient Populations Would a Policy Apply To?

The scope of state policies aimed at hospital price growth varies

States may choose to apply policies:

- **Broadly, applying to everyone covered by private insurance (fully-insured and self-insured plans)**
- **To regulated private insurance markets only**
- **To populations covered by state purchasing only (e.g., state employee plans)**

Policy Examples Impacting Patient Populations

Private Insurance Markets

- Policies across states vary with some focused exclusively on the fully-insured commercial market and others taking a broader approach that also targets the self-insured population
- For example, Rhode Island's direct negotiated rate growth limit policy applies only to the fully-insured market while Vermont's policy is intended to impact the private insurance market more broadly

State Employee Plans

- Oregon has a policy that is aimed at addressing hospital prices for those hospitals that serve state employees through its state employee health plan

Minnesota Patient Population, 2023

Commercial Insurance market	Approximate covered lives	Share of private market
Fully insured commercial	1 million	32.5%
Self-insured commercial	2.2 million	67.5%
Total private insurance	3.2 million	100%

Source: MDH

Questions for Discussion – Scope of Policy

1. What considerations come to mind when thinking about how a Minnesota hospital price growth policy might apply across different categories of hospitals?
2. What opportunities and challenges might arise from using common price growth targets across hospital categories, compared with tailoring targets to different categories?
3. What considerations emerge when exploring the potential reach of a price growth policy across fully insured and self-insured markets?

Scope: Which Services and Sites of Care Would a Policy Apply To?

Inpatient and outpatient hospital facility payments

Initial focus based on the September discussion, but questions around whether other services and settings adjacent to, or closely integrated with, hospital services be included in scope as well

Policy Examples Impacting Services and Sites of Care

Inpatient and outpatient hospital services

- Most policies apply **broadly to inpatient and outpatient services**, excluding professional services
- Example states include: Rhode Island, Delaware, Oregon, Indiana

Prescription Drugs

- Vermont's outpatient administered prescription drug cap applies to **prescription drugs administered in hospital outpatient or office settings**

Questions for Discussion – Applicable Services and Sites of Care

1. What opportunities and trade-offs might arise from a price growth policy that covers both inpatient and outpatient facility services, compared with one focused on a single category?
2. How do freestanding ambulatory surgery centers (ASCs) fit into the broader discussion of a price growth policy's scope?
3. How might a price growth policy affect prices for health system services outside its scope, and what questions does that raise for policy design?
4. What questions emerge when thinking about drugs administered in hospital settings in relation to other hospital services under a price growth policy?
5. What insights from other states' experiences might help us explore these scope questions in Minnesota?

Policy Structure: Should a Policy Have Uniform or Flexible Price Growth Targets?

Uniform Price Growth Target:

Some state policies establish a single target that applies uniformly to all covered hospitals

VS

Flexible Price Growth Target:

Some state policies incorporate flexibility for hospital-specific circumstances (e.g., adjustments based on financial condition, service mix, geography)

Policy Examples Impacting Hospital Specific Adjustments

Adjustment for Lowest-Price Hospitals

- Lowest-price hospitals received a **one-year price bump several years ago** to bring them closer to the median rate.
- Contingent on meeting quality requirements

Role of Hospital in a Service Area

- Vermont's hospital reference-based pricing policy considers **composition of the communities served** by the hospital, including the
  - Health of the population;
  - Demographic characteristics;
  - Acuity;
  - Payer mix;
  - Labor costs;
  - Social risk factors; and
  - Other factors that may affect the costs of providing care in the hospital service area, as well as the hospital's role in Vermont's health care system

Questions for Discussion – Hospital Specific Adjustments

1. How might differences in hospitals' circumstances shape our thinking about price growth targets?
2. What possibilities and concerns come to mind when considering adjustments that would allow higher or lower price growth targets?
3. What are the benefits and tradeoffs between a policy that prioritizes simplicity and uniformity vs. flexibility and equity?

Next Steps

What: Investor Ownership and Influence Working Group

When: November 6, 9 am to 12 pm

Where: Wilder Foundation, Auditorium A



Stay tuned for:

The Health Care Affordability Advisory Task Force November Meeting on November 20th from 1 pm to 4 pm

Thank You!

Center for Health Care Affordability

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