Post-Convening Recap

Milbank Memorial Fund
STATE LEADERSHIP NETWORK

State Approaches to Addressing Hospital Costs: Virtual Convening of Milbank State Leadership Network

May 5, 2025

PANELISTS

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The Milbank State Leadership Network hosted a virtual session for state legislators and legislative staff to discuss factors contributing to rising health care costs as well as opportunities for states to slow spending growth and make health care more affordable with a particular focus on hospital costs. The briefing was hosted in partnership with Bailit Health, the technical assistance provider for the Peterson-Milbank Program for Sustainable Healthcare Costs.

Introduction

Rachel Block, Milbank Memorial Fund

Growing healthcare costs have created an affordability crisis with economic impacts for state governments and employers as well as population health. Block explained that the Peterson-Milbank Program for Sustainable Health Care Costs was created to support states with cost growth target or benchmark programs designed to address this crisis. These programs create a foundation that enables states to establish a goal for annual health care spending growth, collect the data necessary to evaluate how they're performing against that goal, and convene key stakeholders to determine the best policy options based on that data.

The Peterson-Milbank Program provides technical assistance to states, with the support of Michael Bailit and his team, to build state capacity around core program functions, governance, and data analytics. The program has also focused on helping states to identify policy options that best meet the specific cost drivers in their states, and then finally, communicate about the importance of health care affordability. Cost growth target programs are not the only way to address these issues, however, and states are exploring many different approaches to address rising health care costs and improve health care affordability.

Health Care Cost Drivers and Trends

Michael Bailit, Bailit Health Purchasing, LLC

In his presentation, Bailit framed the problem of health care costs, identified what's driving health care spending growth, and highlighted possible policy solutions. He described runaway health care costs as an urgent health problem facing the United States, and one that negatively impacts residents, businesses, and the state economy. For consumers, high and rising health care costs lead to care avoidance, medical debt, and tradeoffs with other necessities like housing and food. For businesses, health care costs crowd out wage growth. Similarly, these costs create state budget strains that leave fewer resources for other priorities.

Between 2018 and 2022, spending increases were largely driven by the rising prices for services rather than increases in utilization. The two major cost drivers were prescription drugs, specifically expensive brand-name drugs, and hospital prices. Hospital pricing varies significantly within and across states, suggesting that prices reflect hospital market power rather than the differences in the quality of care. Hospitals leverage market power to negotiate higher prices and charge more for their services, particularly in highly concentrated markets with little competition.

States can influence health care spending through policies that target spending and address hospital pricing. The table below presents some of the policy options that states are using to address health care costs.

Post-Convening Recap

Menu of State Policy Options to Address Health Care Costs

Global Spending	Hospital Prices
Cost Growth Target Programs: Collect data from public and commercial payers to allow states to track statewide health care spending growth and measure it against an annual growth target, typically tied to an indicator of consumer economic well-being (California, Connecticut, Delaware, Massachusetts, New Jersey, Oregon, Rhode Island, Washington).	Mitigate Provider Consolidation: Obtain notice, review, and approval authorities over health care transactions (e.g. hospital mergers, vertical acquisitions of physician groups). Prohibit anticompetitive health plan contracting terms (e.g. all-or-nothing contracts, anti-steering, gag clauses) using consumer protection and anti-trust laws.
Value-Based Payment: Reward providers for achieving health care quality by increasing incentives for improved outcomes and efficiency through shared savings and risk, or capitated payments.	Cap Provider Rates: Limit the absolute level of provider prices in the commercially insured market, out-of-network payments, state employee health plans, public option, or certain health care services through purchasing authority or insurance regulation (Montana, Oregon (state employee health plan).
Insurance Rate Review: Constrain insurance premium growth in state-regulated health insurance markets.	Cap Provider Rate Increases: Place an upper limit on how much an insurer can annually increase prices for overall prices or specific services, based on baseline provider prices, through insurance regulation (Rhode Island).

Hospital Cost Containment Efforts – Lessons from Washington State

June Robinson, State Senator, Washington State Senate

Senator Robinson explained that in 2020, Washington established a Healthcare Cost Transparency Board to track health care spending. In 2024, the Board completed its first benchmark report, showing that statewide spending exceeded the benchmark, particularly for outpatient hospital services. In addition, the state legislature directed the Office of the Insurance Commissioner to analyze policy options for cost containment. Using state economic and cost analysis data, the office, in 2024, recommended a reinsurance program, medical loss ratio reduction, reference-based pricing, and global budgeting.

During the 2025 legislative session, Washington passed a bill on reference pricing for state and school employee health plans modeled on Oregon's approach. The bill set a reimbursement cap for hospital services and a reimbursement floor for primary care and behavioral health services using Medicare levels as a reference. Key Provisions of the bill:

- Cap hospital payments at 200% of Medicare rates
- Set a floor of 150% of Medicare rates for primary care and behavioral health
- Exempt critical access and sole community hospitals
- Use an alternative methodology for children's hospitals
- Cap out-of-network payments at a lower rate

To pass the legislation, Senator Robinson said, proponents of the bill focused on the need to rebalance health care spending priorities by lowering excessive hospital prices and boosting underpaid services. The proponents leveraged budget challenges and emphasized the cost savings for the state and school employees in the third and fourth years of the four-year budget. Public employee and school employee unions, along with consumer and patient advocacy groups and behavioral health providers, were strong allies for the bill. Opponents included insurance companies and hospitals, particularly children's hospitals and rural hospitals that were subsequently able to negotiate exemptions.

Senator Robinson also noted the political momentum created by the Washington Health Care Authority's request for the bill. "Staff at the Healthcare Authority were very helpful along the way in providing the necessary data and research to back up the policy and the bill," she said.

Colorado Health Care Affordability Landscape

Kyle Brown, PhD, State Representative, Colorado General Assembly

Colorado has had several health care affordability legislative successes over the last six years, including the creation of the Colorado public health plan option, which included rate setting, and expanding access to more affordable quality health care for undocumented people, and creating a prescription drug affordability board (PDAB). This year,

Post-Convening Recap

Representative Brown introduced legislation in partnership with the governor's office to use a rate setting approach for the state employee health plan to generate savings to fund safety-net hospitals in the state. The bill was designed to support safety-net providers after more than half a million people lost coverage during Medicaid unwinding, which particularly strained federally qualified health centers (FQHCs) and community mental health centers. Though the bill had enough votes to pass the House, it faced opposition in Senate health committee due to hospital opposition to rate setting. A bill with a counterproposal to stabilize FQHC funding with unclaimed property trust fund dollars passed.

Representative Brown also sponsored a bill based on the NASHP model legislation and other state efforts to include public interest in review of transactions between nonprofit entities that are not subject to scrutiny from the Attorney General's Office or any other state entity. Despite union support, the bill did not pass, though there are ongoing discussions with the hospital association planned for the summer. Other bills to shore up funding for the state reinsurance program and coverage for undocumented immigrants were also unsuccessful despite, and in some cases because of, looming federal funding cuts that would impact the individual marketplace.

Representative Brown noted that these affordability initiatives lacked the same political will as the successful public option legislation. Additionally, as health care prices rise and as households worry about the price of eggs, raising additional revenue for community health center through fees or taxes became unpopular, he said. He also noted the opposition from industry and the business community. Hospitals in Colorado presented a united front against affordability legislation — even rural hospitals exempt from the bill — arguing that threats to urban systems would still impact them.

Discussion: Getting Legislation Across the Finish Line

Both participants discussed data sources that were helpful for getting bills across the finish line. In Colorado, Representative Brown used the Department of Health Care Policy and Financing's breakeven analysis tool, which helped reveal that hospitals claiming financial hardship were actually operating with healthy margins. Data from NASHP's national Hospital Cost Tool, which shows each included hospital's "commercial breakeven," was also persuasive in legislative committee discussions. Senator Robinson added that the Washington Health Authority provided her with a list of hospitals already contracted below the proposed reimbursement cap (200% of Medicare). This information allowed her to show lawmakers that their local hospitals could, and already did, operate under the proposed cap — helping to dispel misleading narratives.

During the discussion, participants explored strategies for building coalitions to support health care affordability reforms amid political polarization and budget constraints. Representative Brown emphasized partnerships with community-based organizations like Colorado's Center for Health Progress, consumer advocates, and unions, but noted that the enduring political power of hospitals limits the influence of grassroots support. Senator Robinson described similar dynamics in Washington, where hospitals also unified in opposition to cost-containment legislation. She pointed to the difficulty of getting community voices heard in the legislature, despite the presence of nonprofit groups working on broader tax and equity issues. Both lawmakers expressed interest in engaging the business community as a potentially powerful and underutilized ally in building cross-sector support for health care affordability reforms.

Resources

- How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan
- Hospital Payment Cap Simulator
- Model Legislation and Resources to Address Rising Health Care Costs
- Hospital Cost Tool for State Policymakers – With Updated Data
- SageTransparency2.0
- A Menu of State Choices for Addressing Unaffordable Growth in Hospital Commercial Prices
- Guide to Hospital Price Growth Targets