# Focusing Hospital Affordability Policies on the Haves and Protecting the Have-Nots

Webinar
October 30, 2025

bailit health

Peterson-Milbank Program for Sustainable Health Care Costs

# Peterson-Milbank Program for Sustainable Health Care Costs

**The Peterson-Milbank Program for Sustainable Health Care Costs supports state-led efforts to make health care more affordable for everyone.**

This support includes direct technical assistance to individual states in analyzing and addressing the underlying drivers of health care cost growth, regular opportunities for peer networking, as well as the facilitation of cross-state projects on shared affordability priorities.

# Speakers

- Michael Bailit, President, Bailit Health
- Sarah Kinsler, Senior Consultant, Bailit Health
- Owen Foster, Chair, Green Mountain Care Board, Vermont
- Julie McGuire, Indiana State Representative
- Vishaal Pegany, Deputy Director, California Office of Health Care Affordability

# Separating the Haves from the Have-Nots

## *State Options for Targeted Application of Hospital Affordability Policies*

Sarah Kinsler and Michael Bailit

bailit health

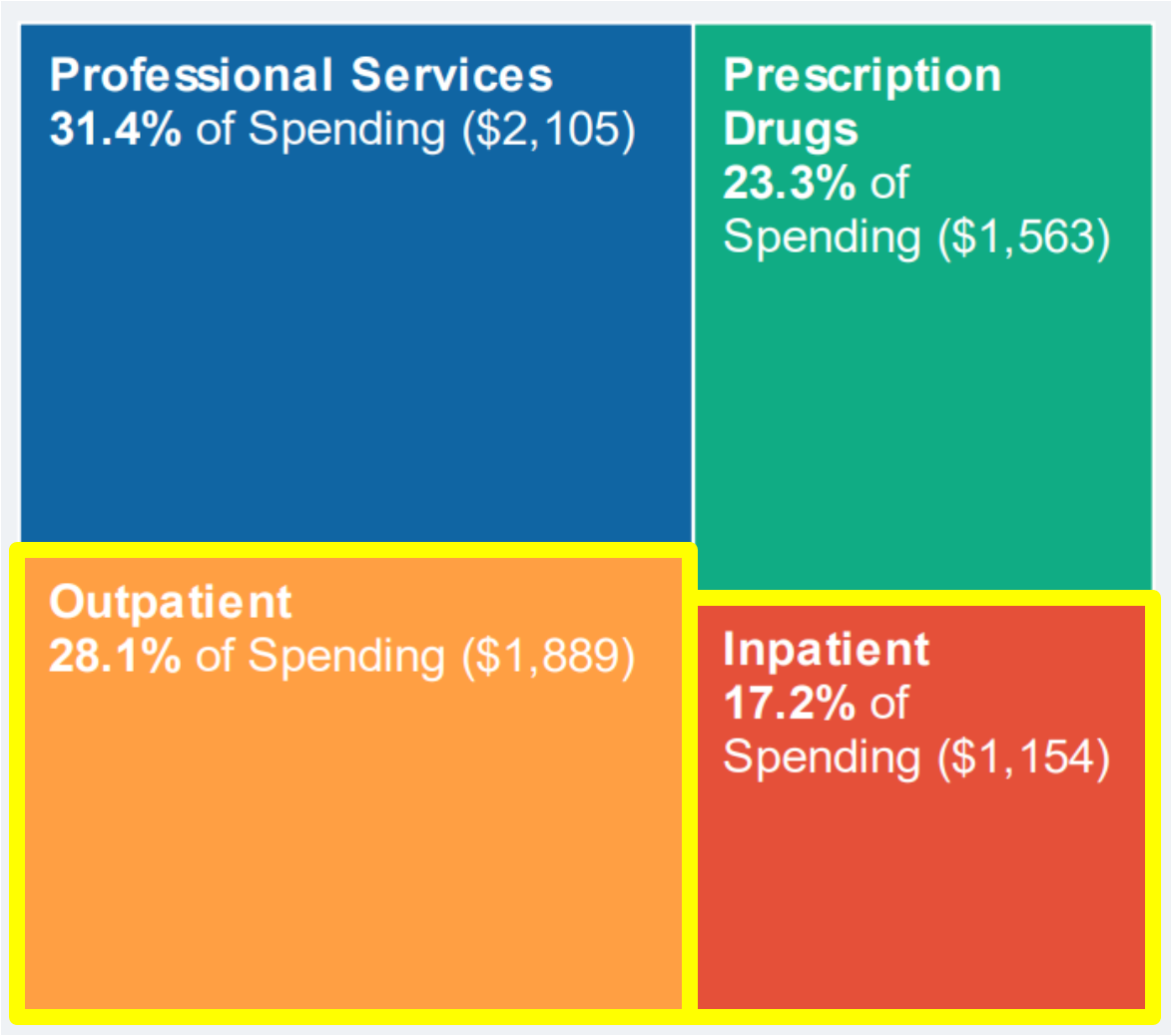
Peterson-Milbank Program for Sustainable Health Care Costs

# Agenda

1. Setting the Stage: Why target application of hospital affordability policies?
2. Identifying “Have” and “Have-Not” Hospitals
3. State Options for Targeting Hospital Affordability Policies
4. Discussion: Indiana, California, and Vermont
5. Audience Q&A

# Nationally, hospital spending makes up the largest share total commercial health care spending.

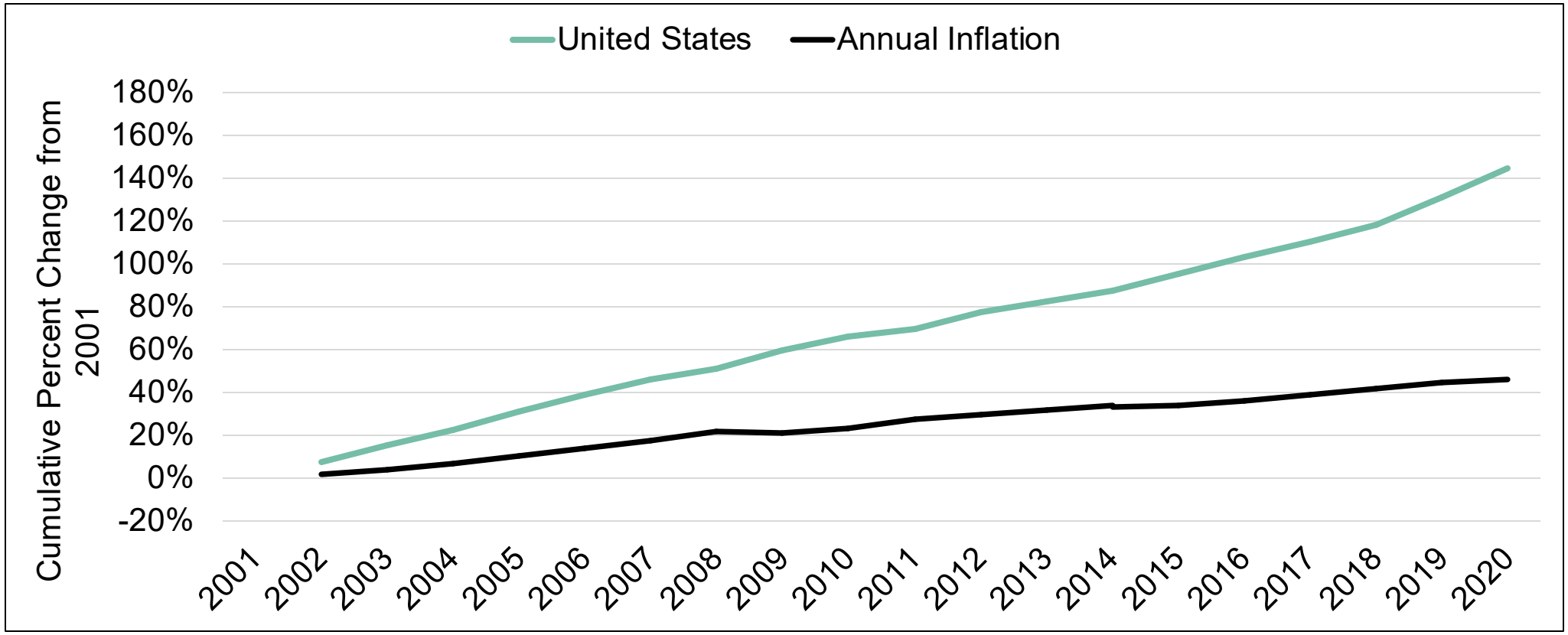
**Share of Per Capita Spending in 2022**




**Source:** Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. April 2024.

# Hospital Spending Has Grown Rapidly!

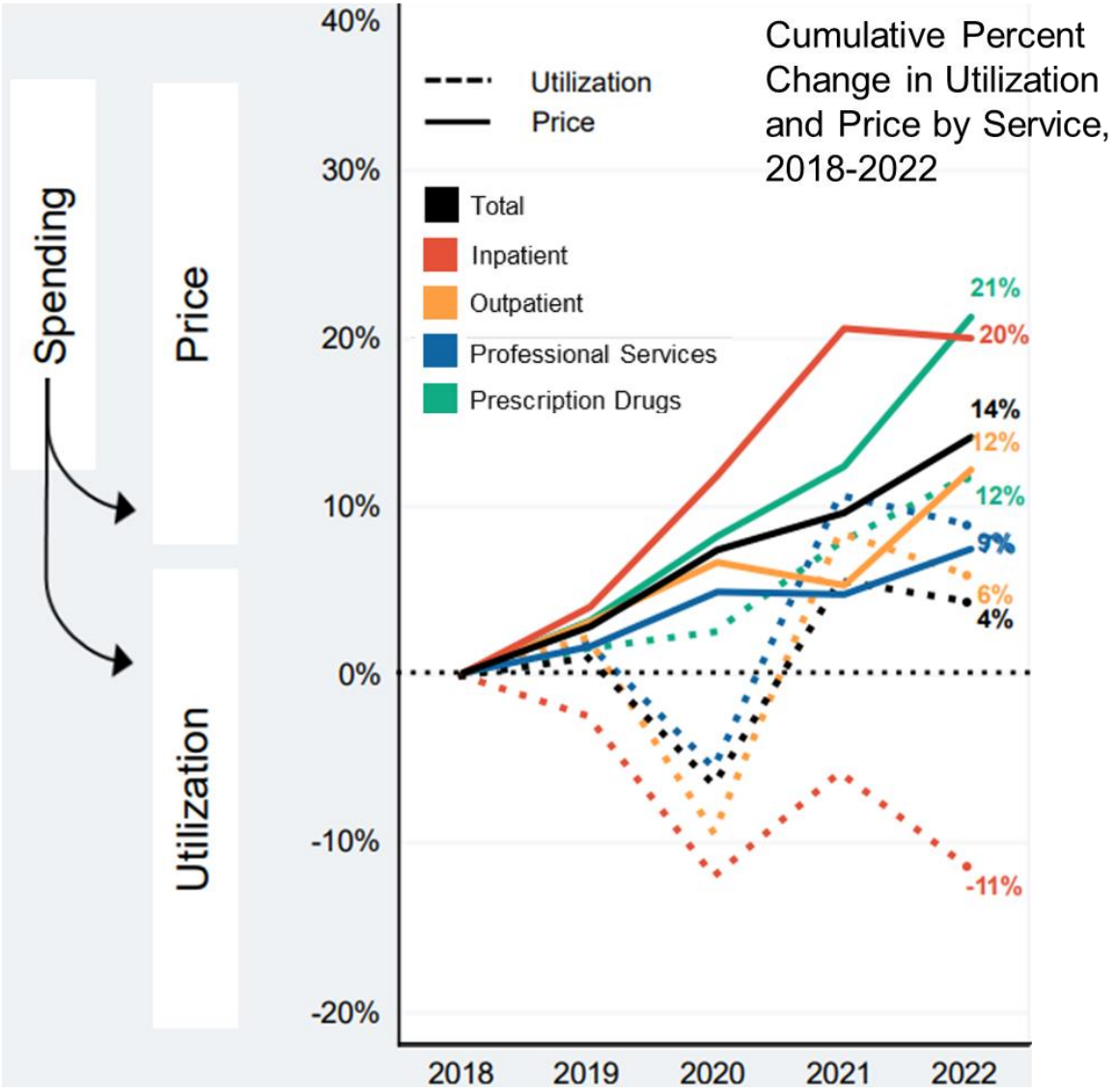
## Cumulative Growth in Per Capita Hospital Expenditures, 2001-2020




Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). *National Health Expenditure Data: Health Expenditures by State of Residence, August 2022*. and Federal Reserve Bank of St. Louis. (2024).

# Price growth has been the primary driver

- From 2017-2022, spending increases across service categories were largely driven by **rising prices**.




Source: Health Care Cost Institute. 2022 Health Cost and Utilization Report, April 2024, https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports

# While hospital prices have been the major cost growth driver…

## …hospitals push back on accountability and on proposed affordability policies.

- Hospitals argue state policies meant to decrease or slow growth in hospital costs will have disastrous financial impact and could force them to make service cuts or even close facilities, endangering patient access to care.

# The More Complicated Truth

## Hospital and health system finances vary greatly.

### *The Haves…*

- Significant reserves
- Strong market power → high commercial prices
- More likely to be large systems
- More likely to be located in high-income communities

### *The Have-Nots…*

- Low assets
- Low market power → lower commercial prices
- More likely to be small or independent
- More likely to be located in low-income communities

A new Peterson-Milbank publication suggests how states can design policies that recognize this variation.

# Why Target Application of Hospital Affordability Policies?

- The "**Haves**" are frequently the largest contributors to spending growth due to the combination of high prices and high patient volume.
- Targeted affordability policies can address this dynamic without endangering "**Have-Not**" hospitals that truly are financially precarious.

# Limitations of a Targeted Approach as Compared to a Universal Approach

- More limited impact on commercial market affordability
- Uneven impact on consumers
- More complicated for states to implement
- Potential for gaming (e.g., lobbying to be recategorized as "Have Not")

# Identifying Have and Have-Not Hospitals

- **Basic Method**
  - Credit rating

    *For additional context, consider commercial prices and payer mix.*
- **Comprehensive Approach**
  - Liquidity: Days Cash on Hand
  - Profitability: Operating EBITDA & Total EBITDA Margin

    *For additional context, consider measures of debt capacity/solvency and capital investment.*

***How to choose?***

- Expertise
- Resources
- Planned uses

*…or combine aspects of both*

EBITDA = Earnings Before Interest, Taxes, Depreciation, and Amortization

# Identifying Have and Have-Not Hospitals
## *Basic Method*

- **Credit Rating:** Reliable indication of financial health for independently rated hospitals and health systems.
  - Key factors include liquidity (cash on hand), profitability, market share, and payer mix.
  - Suggested thresholds:
    - Haves = "high quality" ratings;
    - Have Nots = "below investment grade" ratings

*For context, also consider:*
- Current commercial price (RAND)
- Payer mix

*Downsides:* Not all hospitals and systems are independently rated. Small hospitals and those with poor financial health are less likely to be rated; private equity-owned hospitals are often unrated. Information may not be the most current.

# Identifying Have and Have-Not Hospitals *Comprehensive Approach*

*Pursue the Comprehensive Approach if you have the expertise or the planned resources, or you plan to use these data for regulatory purposes.*

- **Liquidity: Days Cash on Hand**
  - Represents unrestricted reserves, expressed as a multiplier of daily operating expenses; reflects hospitals' ability to weather financial challenges
  - Suggested thresholds:
    - Haves = >200 days cash on hand
    - Have-Nots = <75 days cash on hand (except for-profit hospitals)
  - Critical to capture all unrestricted sources at the system-level

# Identifying Have and Have-Not Hospitals *Comprehensive Approach*

- **Profitability: Operating EBITDA and Total EBITDA Margin**
  - Assess whether the hospital makes money on core operations (providing patient care) and on their entire business, inclusive of non-operating income and losses, including realized investment gains.
  - Suggested thresholds (average over 3-5 years):
    - Haves = Operating EBITDA margin >8%, total EBITDA margin >10%
    - Have-Nots = Operating EBITDA margin <2%, total EBITDA margin <0%
  - Expect to see positive margin in some years and negative margin and others; always look at averages and trends over multiple years.

EBITDA = Earnings Before Interest, Taxes, Depreciation, and Amortization
Realized investment gains: Income from sales of investments

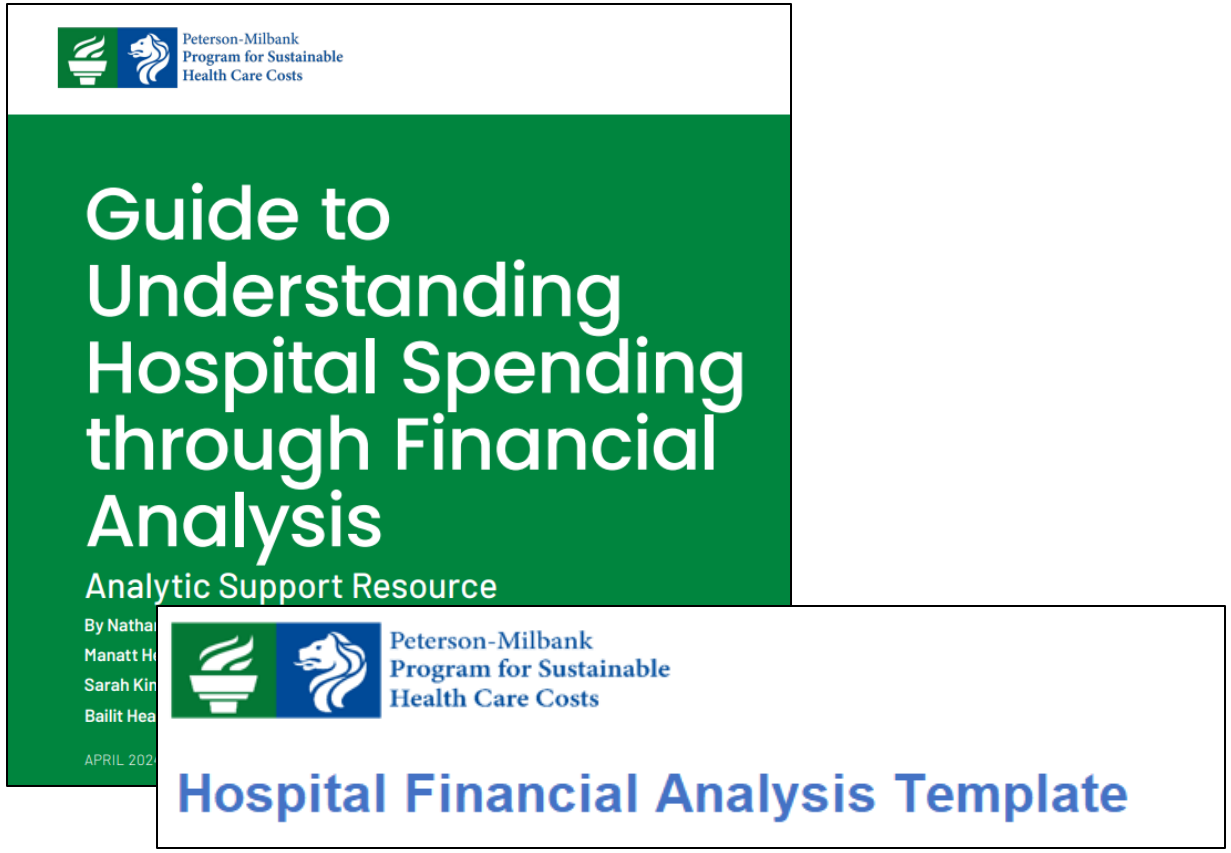
# Identifying Have and Have-Not Hospitals *Comprehensive Approach*

- **Additional measures for consideration:**

  *Debt Capacity and Solvency:*
  - EBITDA debt-service coverage
  - Long-term debt to capitalization

  *Capital Investment:*
  - Capital expenditures to depreciation
  - Average age of plant

*For support analyzing hospital audited financial statements: Peterson-Milbank Guide to Understanding Hospital Spending through Financial Analysis*




EBITDA = Earnings Before Interest, Taxes, Depreciation, and Amortization
Realized gains/losses: From sales of investments (*not* changes in portfolio value)

# State Options for Targeted Application of Hospital Affordability Policies

1. Hospital price caps and/or price growth caps
2. Measuring and reporting hospital price growth against a target
3. Site-neutral payments and limitations on outpatient facility fees

# How to Target Application of Hospital Affordability Policies

1. **Exempt the "Have Nots."**
   - *Example:* Allow prices at "Have-Not" hospitals to exceed price cap level.
2. **Target the "Haves."**
   - *Example:* Direct site-neutral payment policies or facility fee bans/limits at "Have" hospitals or those with high prices.
3. **Employ tiered approaches.**
   - *Example:* Apply higher price caps or price growth caps to "Have Nots", and more stringent price caps or price growth caps to "Haves."

# State Option: Hospital Price Cap and/or Price Growth Cap

- A **price cap** (a.k.a., payment limit, payment cap, or provider-based reference pricing) limits payment amounts for hospital services.
  - Reference an external payment benchmark, usually Medicare.
  - Typically apply to inpatient and outpatient hospital services.
- A **price growth cap** limits annual price increases.
  - Reference a measure of inflation or a state's cost growth target.

# State Price Cap and Price Growth Cap Models

*State examples include:*

Oregon (state employee health plan price cap)

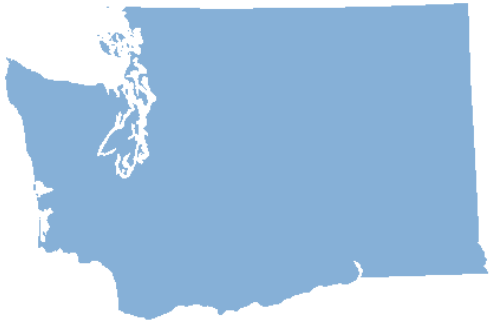
Rhode Island (hospital price growth cap)

*Recent legislative action:*

In 2024…

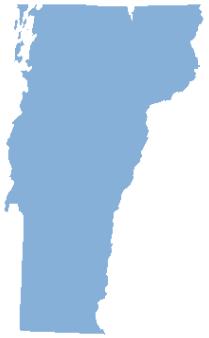
Delaware

In 2025…



Washington

Indiana



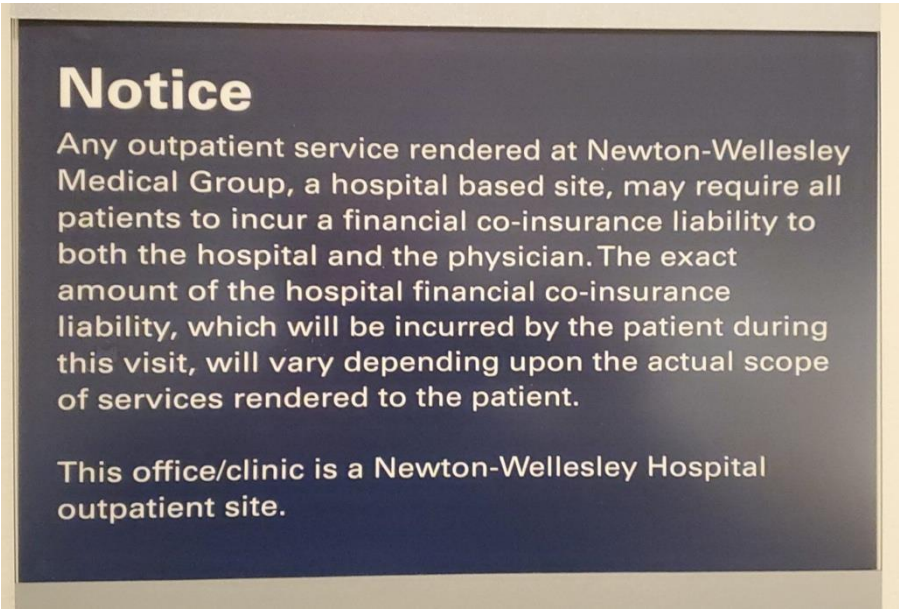
Vermont

# State Option: Measuring and Reporting Hospital Price Growth Against a Target

- A **hospital price growth target** introduces a public expectation for price growth rather than capping growth through regulation.
- To be effective, hospitals and health systems must have an incentive to meet the target: public scrutiny. Requires:
  - Transparent state measurement of hospital price growth
  - Public and policymaker education
  - Communications strategies that call out entities that exceed the target

# State Option: Site-neutral Payments and Limitations on Outpatient Facility Fees

- **Site-neutral payment policies** limit hospitals' ability to charge higher prices than nonhospital providers for services that can be safely provided in nonhospital settings.
- Policies that **limit or ban facility fees** for some outpatient services prevent hospitals from charging additional amounts on top of payments for medical care.



# State Examples: Site-neutral Payments and Limitations on Outpatient Facility Fees

Many state examples, including…

Connecticut

Colorado

Indiana

# Key Takeaways

1. Hospitals say they are financially precarious and can't bear state affordability policies without cutting services or risking closure, but **this is not true for all hospitals and systems**.
2. States can **use existing data sources to assess hospitals' claims**, including credit ratings and rating commentaries, the RAND Hospital Price Transparency Study, and state-collected hospital audited financial data, where available – but review of audited financials may be needed.
3. By targeting the Haves, states can **address the hospitals that tend to have the highest prices and highest contribution to commercial market unaffordability**.
4. States should **be wary of hospital efforts to game exemption criteria**.

# Discussion: State Panelists

# State Panelists

- Julie McGuire, Indiana State Representative
- Vishaal Pegany, Deputy Director, California Office of Health Care Affordability
- Owen Foster, Chair, Vermont Green Mountain Care Board

# California: High-Cost Hospitals Metrics

## Commercial Unit Price for Repeat Outlier Hospitals, 2018-2022

| Hospital | 2018 | 2019 | 2020 | 2021 | 2022 | Pooled Avg 2018-22 |
|---|---|---|---|---|---|---|
| **All Other Comparable Hospitals** | $20.1K | $19.8K | $20.2K | $20.4K | $21.1K | $20.3K |
| **7 High-Cost Hospitals** | $36.3K | $39.7K | $40.1K | $42.1K | $43.8K | $40.4K |
| Community Hospital of The Monterey Peninsula | $32,729 | $41,866 | $42,292 | $43,655 | $38,891 | $39.9K |
| Doctors Medical Center – Modesto | $27,288 | $40,915 | $35,947 | $36,831 | $39,679 | $36.0K |
| Dominican Hospital | $37,237 | $33,720 | $33,201 | $34,923 | $33,291 | $34.5K |
| Salinas Valley Memorial Hospital | $46,937 | $43,061 | $44,748 | $50,400 | $48,784 | $46.7K |
| Santa Barbara Cottage Hospital | $31,185 | $30,325 | $36,617 | $32,636 | $33,596 | $32.8K |
| Stanford Health Care | $47,705 | $47,374 | $49,091 | $53,366 | $58,873 | $51.5K |
| Washington Hospital – Fremont | $32,200 | $33,404 | $30,929 | $33,082 | $35,432 | $32.9K |

Key: above 85%

# California: High-Cost Hospitals Metrics

## Relative Commercial to Medicare Price for Repeat Outlier Hospitals, 2018-2022

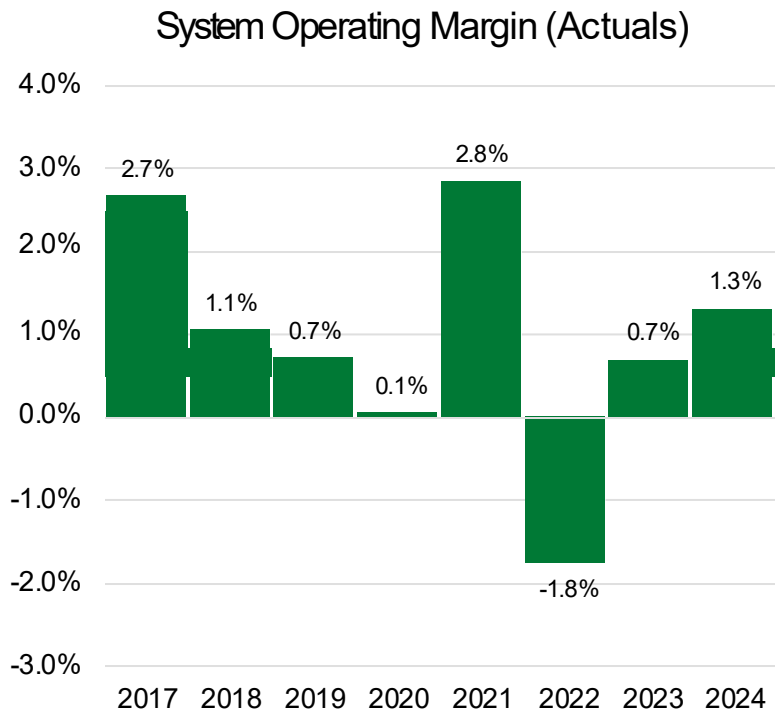
| Hospital | 2018 | 2019 | 2020 | 2021 | 2022 | Pooled Avg 2018-22 |
|---|---|---|---|---|---|---|
| **All Other Comparable Hospitals** | 203% | 200% | 201% | 191% | 198% | 198% |
| **7 High-Cost Hospitals** | 323% | 365% | 350% | 355% | 362% | 351% |
| Community Hospital of The Monterey Peninsula | 238% | 437% | 353% | 363% | 369% | 354% |
| Doctors Medical Center - Modesto | 326% | 372% | 343% | 325% | 372% | 348% |
| Dominican Hospital | 355% | 314% | 336% | 316% | 334% | 331% |
| Salinas Valley Memorial Hospital | 405% | 457% | 461% | 556% | 501% | 475% |
| Santa Barbara Cottage Hospital | 293% | 300% | 310% | 310% | 311% | 305% |
| Stanford Health Care | 326% | 335% | 339% | 351% | 340% | 338% |
| Washington Hospital – Fremont | 347% | 392% | 352% | 328% | 363% | 358% |

Key: above 85%

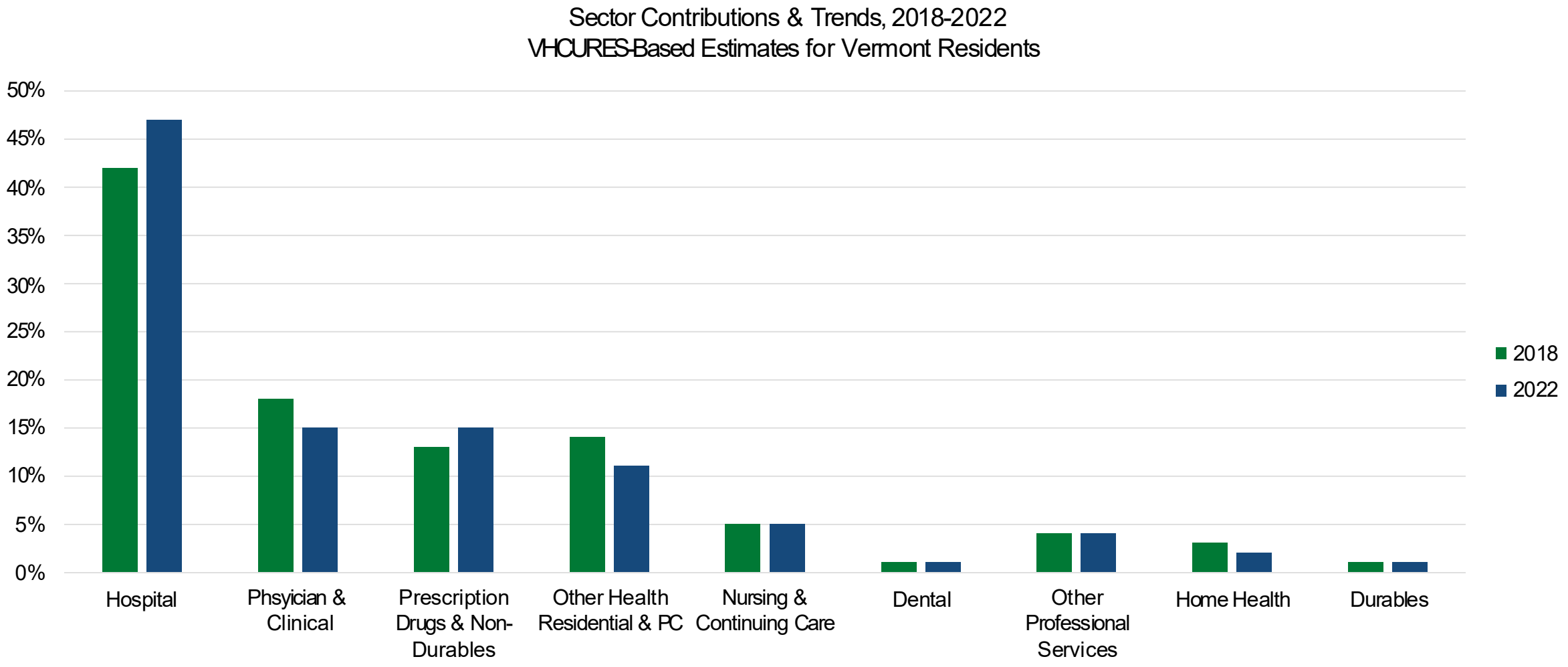
# Solvency Risks Necessitate Immediate, Significant and Intentional Transformation

| | Operating Margin | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Hospital** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Brattleboro Memorial Hospital | -3.1% | -2.4% | 0.8% | 0.6% | -1.7% | -3.8% | -1.7% | -5.1% | -2.3% |
| Central Vermont Medical Center | -0.9% | -3.8% | -2.1% | -0.6% | -1.0% | -6.5% | -6.5% | 1.7% | -0.8% |
| Copley Hospital | -0.6% | -3.3% | -3.2% | -3.9% | 5.1% | -0.7% | -1.3% | 1.2% | 1.6% |
| Gifford Medical Center | -1.6% | -10.7% | -0.8% | 2.5% | 8.8% | 7.0% | -8.3% | -18.2% | -4.3% |
| Grace Cottage Hospital | -6.9% | -2.9% | -6.7% | 1.1% | 8.0% | -6.8% | -7.2% | -9.9% | -0.4% |
| Mt. Ascutney Hospital & Health Ctr | 2.7% | 1.9% | -0.1% | 0.9% | 9.1% | 1.7% | 2.0% | 1.2% | 0.4% |
| North Country Hospital | -2.3% | -2.3% | 1.9% | 3.7% | 7.0% | -10.3% | -8.9% | -2.5% | 0.2% |
| Northeastern VT Regional Hospital | 1.9% | 1.7% | 1.8% | 1.3% | 2.9% | 0.2% | -3.6% | 0.1% | -1.4% |
| Northwestern Medical Center | -1.2% | -3.4% | -8.0% | -0.9% | 4.7% | -4.3% | -6.6% | -2.5% | -2.4% |
| Porter Medical Center | 2.7% | 1.8% | 5.2% | 4.1% | 7.7% | 3.1% | 7.6% | 4.7% | 4.6% |
| Rutland Regional Medical Center | 1.6% | 0.5% | 0.4% | 0.2% | 2.2% | -3.8% | 2.1% | 0.9% | 4.6% |
| Southwestern VT Medical Center | 3.7% | 4.6% | 3.3% | 2.8% | 4.5% | -0.2% | -3.8% | 0.0% | -0.8% |
| Springfield Hospital | -7.1% | -12.8% | -18.4% | -11.2% | 1.2% | 5.4% | -0.9% | -1.1% | -3.7% |
| The University of Vermont Medical Center | 5.2% | 3.4% | 2.2% | -0.3% | 2.3% | -1.2% | 3.1% | 2.7% | 2.7% |

***FY17-24 Actuals, FY25 Projected***



# Hospital spending is a major driver of health care spending



# Q&A

# Thank you!

Peterson-Milbank
Program for Sustainable
Health Care Costs