Hospital Rate Setting in the United States: History, Evidence, and a Stepwise Path for States

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ABSTRACT

Since the mid-1990s, hospital consolidation has given health systems the power to raise commercial prices. Such consolidation has undermined the competitiveness of hospital markets, resulting in managed care, antitrust enforcement, and voluntary payment models being unable to limit price increases. It has also contributed to rising health care costs that have made health care increasingly unaffordable for individuals, families, and workers. In the 1970s and 1980s, hospital prices were also rapidly increasing and some states concluded that the problem could not be corrected by purchasers acting individually. These states turned to public-utility-style rate-setting systems to set prices for hospital services that applied to all payer categories. This report examines what those systems achieved, why most were repealed, and what states can learn from them. The states with mandatory rate-setting systems reduced cost growth relative to unregulated states, narrowed payment differences across payers, and stabilized the finances of hospitals, particularly those serving low-income populations. Although most systems were repealed in the 1990s due to a variety of factors, Maryland avoided these problems through the broad delegation of regulatory authority to its commission, a formula-based rate-setting approach, general oversight designed to deter gaming, and an expert, well-resourced agency. Drawing on these lessons, the report describes a path for states to reconsider hospital rate setting, including a stepwise path to implementation.

POLICY POINTS

- From the 1970s through the 1990s, states with mandatory hospital rate setting slowed hospital cost growth relative to unregulated states, with all-payer systems experiencing the best cost-containment success. Most systems ended because of avoidable design choices, not because rate regulation failed. Maryland's system avoided those choices and has operated for five decades.
- States can build rate-setting capacity in stages. They can begin with partial-market payment caps, extend caps to all commercial payers, and then pursue all-payer global budgets with federal cooperation.

INTRODUCTION

Rate setting has been used in this country and many others for health care and other essential services supplied in markets where competition is too weak to constrain prices.

Most US hospital markets are now highly concentrated and non-competitive.[1] Consolidated hospitals and health systems increasingly use that market power to demand higher prices from private insurers, eroding the affordability of employer-sponsored insurance[2] and producing broader economic and social harm, including wage suppression, reduced employment, and reduced tax revenue.[3] Price growth accelerated further after the Affordable Care Act's insurance expansions because the larger, better-insured patient population gave hospitals more leverage to raise prices with less price resistance from patients.[4]

Many interventions for constraining hospital prices have already been attempted, and each has proven inadequate. Managed care held prices down through the 1990s by directing patients toward narrow, price-competitive networks. Hospital consolidation later undercut this approach, because a plan could not exclude a dominant system and still offer a network that employers would buy.[5] Antitrust enforcement can slow consolidation, but it has not yet been used to unwind the market power hospitals have accumulated, and courts and policy analysts are skeptical that breaking up merged hospital systems is a realistic remedy.[6,7] Value-based payment models and other voluntary federal initiatives have had limited effect, since providers that do not benefit from a voluntary program can simply decline to participate or drop out.[8]

Rate setting avoids these failings by having a regulator set and enforce prices directly. Rate setting has been used in this country and many others for health care and other essential services supplied in markets where competition is too weak to constrain prices.[9,10] Congress has not seriously considered hospital payment reform at the federal level in many years,[11] but states can exercise authority to regulate prices directly. As this paper describes, several already have and many are moving in this direction.[12]

This paper traces the history of US state-based rate-setting systems, the conditions that produced rate setting in a number of states in the 1970s, what it accomplished, why most systems were later abandoned, and why Maryland's survived. It draws four lessons from that record, then proposes a stepwise path by which states can build the same kind of effective regulatory capacity today.

HISTORICAL CONTEXT

The Problems Rate Setting Was Built to Address

In the period after World War II, hospitals were paid by many different methods.[13,14] Commercial insurers reimbursed patients, who then paid the hospital's billed charges directly.[15] Blue Cross plans negotiated terms with hospitals individually and paid hospitals based on a percentage of charges, or on incurred costs, depending on the plan.[16] The American Hospital Association endorsed cost-based reimbursement in 1953, and when Congress created Medicare and Medicaid in 1965, it adopted this cost-based payment approach to secure hospital industry support.[17] The fundamental design problem with this

system was that a hospital that spent more on operating and capital costs in a given year was then paid more in a subsequent year. Conversely if a hospital lowered its costs, its payments would be reduced in future years. As a result, cost-based reimbursement perversely penalized hospitals for improved operating efficiency. Through the early and mid-1970s, this largely unconstrained financing system resulted in national hospital expenditures that grew by roughly 13% to 14% annually.[18]

These cost-based public payers reimbursed hospitals only for the allowable costs of their own patients and contributed nothing toward bad debt or charity care.[19] The charge-paying commercial payers then absorbed the difference, effectively cross-subsidizing Medicaid and Blue Cross.[14] Accordingly, hospitals serving disproportionately uninsured and low-income populations had too few charge-paying patients to adequately offset such losses.[19,20] In the 1970s, a hospital's financial viability depended primarily on its proportion of better-paying commercial insurers, and the greatest financial strain fell on the institutions least able to bear it. In Maryland, hospitals serving large numbers of non-paying patients approached insolvency, and some began turning away patients without insurance.[19]

Instead of reimbursing costs after they were incurred, states set rates prospectively, meaning the regulator fixed what a hospital could charge in advance of the period in which the care would be delivered.

The Foundations of Rate Setting

By the early 1970s several states had concluded that these problems could not be corrected by purchasers acting individually and began setting hospital rates directly.[21] The justification for rate setting came from the public utility tradition, in which the government controlled prices for essential services supplied in markets that lack sufficient market forces to incentivize efficiency.[10, 21] Hospital care is an essential service for which market entry is capital intensive and constrained by licensure. Patients typically cannot compare prices at the moment they need care, and physicians, rather than patients, direct most purchasing decisions.[23] Cost-based payment methods obligated purchasers to reimburse whatever hospitals spent, leaving purchasers no ability to contest price. When competition cannot set price, the public utility tradition holds that a public body should set it and be subject to procedural protections for the regulated firm.[10,24]

Rate-setting statutes that were passed in the 1970s were primarily passed to slow the growth of hospital costs, but a few states pursued broader aims.[25] For instance, Maryland established three economic and societal goals that directed its cost commission: 1) constrain hospital cost growth; 2) ensure that hospitals have the financial ability to provide efficient, high-quality services to all Marylanders; and 3) increase the equity or fairness of hospital financing.[25]

Meeting these goals required a different way of paying hospitals. Instead of reimbursing costs after they were incurred, states set rates *prospectively*, meaning the regulator fixed what a hospital could charge in advance of the period in which the care would be delivered. This approach reversed the incentives of the cost-based system, because a hospital that incurred costs below the approved rate could keep the difference rather than surrendering it through a lower base the following year. Improved efficiency now rewarded hospitals' revenue rather than penalizing them.

Congress authorized federal participation in these state-based rate-setting models[26] and in the 1970s and 1980s, Maryland, New York, Massachusetts, and New Jersey obtained waivers to include Medicare payments in their rate-setting systems.[25,27] In 1983, Congress

adopted a prospective payment system for Medicare itself and, in the same legislation, created a pathway for states that wanted to run their own rate-setting system.[28]

EARLY ADOPTERS: MOTIVATIONS AND METHODS

Prospective rate setting began in a program operated in Southwest Ohio in 1948.[29] The first law enacting a state-based rate-setting system was enacted by New York in 1969 and initially set prospective rates for Medicaid and Blue Cross.[21] New Jersey enacted enabling legislation in 1971 and began setting rates for Medicaid and Blue Cross in 1974. Maryland's Health Services Cost Review Commission (HSCRC) was created in 1971 and took jurisdiction over hospital rates in 1974. Massachusetts, which passed legislation in 1968, began regulating in 1975 after a budget crisis and rising Medicaid spending. Washington began in 1975 and Connecticut in 1976.[30]

By 1980 more than 30 states had adopted some form of prospective rate setting or budget control, but only a few gave their regulators authority to mandate compliance with established rates.[21,30] Most programs were voluntary, and voluntary systems did not constrain spending, because hospitals that found the rates too tight simply declined to comply or withdrew.[30] As of 1978, eight states both required all hospitals to participate and empowered their commissions to determine or alter rates: Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New York, Washington, and Wisconsin.[24] In 1980, a group of hospitals in Rochester, New York, obtained approval to opt out of the state's broader rate-setting system and operate under a regional global budget demonstration, the Hospital Experimental Payment Program (HEPP), which ran from 1980 to 1987.[31,32,33] West Virginia's system, which applied to private insurers including Blue Cross, operated from 1985 until 2016.[34]

The rate-setting systems had support from broad coalitions, but this support came primarily through self-interested lobbying by organized groups rather than from any mobilization of citizens. Hospitals, insurers, employers, labor unions, and state officials all supported rate setting, albeit for different reasons.[21] The American Hospital Association backed state rate setting in the 1970s as a preferable alternative to federal controls that might be less responsive to key policy goals at the state level. In fact, Maryland's statute was initially drafted by the Maryland Hospital Association. Commercial insurers wanted protection from cost-subsidization by Blue Cross and public payers. Employers and labor unions wanted relief from increasing health insurance costs, and state officials wanted to contain rapidly growing Medicaid costs and protect state budgets. Each of these groups supported rate setting because it served a particular interest, but when rate setting no longer appeared to advance their self-interested priorities, their support faded.

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What Rate Setting Achieved

During the time they operated, these systems produced real and measurable results across four areas: 1) cost containment, 2) payment equity and access, 3) hospital financial stability, and 4) the capacity to accommodate delivery system change and payment innovation. The degree of success varied across states and across these four policy goals, with Maryland and

Rochester generally being the strongest performers and the states that later abandoned rate setting achieving more mixed results.[31] Rate systems that legally mandated compliance with established rates were the most successful and these mandatory systems consistently outperformed voluntary rate review models.[29]

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Cost containment. The research literature from the 1970s and 1980s conclusively shows that mandatory and all-payer rate-setting systems reliably slowed the growth of hospital costs relative to comparable, unregulated hospitals.[35,36] A regression analysis across all mandatory rate-setting states found that mature programs reduced hospital cost growth by roughly 3 to 4 percentage points a year relative to non-regulated states.[36] The regional all-payer demonstration in Rochester was similarly effective. Rochester-area hospitals held their five-year expense growth to 46%, compared with 52% for New York hospitals generally and 68% for United States hospitals overall.[33]

Payment equity and access. Some rate-setting systems, including those in Washington and Maryland, were required by statute to set rates more equitably among all purchasers without "undue discrimination or preference" and that requirement was incorporated into the terms of Maryland's Medicare waiver.[37,38] Other rate-setting states narrowed the payment differentials that had existed among Medicare, Medicaid, Blue Cross, and commercial insurers by funding uncompensated care directly and more equitably through regulated rates.[21] New Jersey and New York built regional pools that financed hospital uncompensated care through rate surcharges and directed funds back to hospitals based on their reported bad debt and charity care.[39,40] Maryland took a different approach and built an allowance for uncompensated care into each hospital's approved rates. Because all payers paid the same rates at a given hospital, all payers shared the cost of uncompensated care.[19] After the Affordable Care Act, the amount of uncompensated care decreased and the commission was able to reduce these markups from 8% to approximately 4%.[41] The HSCRC also created a pool to equalize the magnitude of uncompensated care funding across hospitals so as not to disadvantage the price competitiveness of hospitals that treated disproportionately high numbers of uninsured patients.[21]

New York and New Jersey followed a similar approach and experienced more success stabilizing distressed hospital finances than in improving access for uninsured patients. In New York, per-capita utilization by uninsured patients kept declining after the pool began, but at a slower rate than before, and most of the pool's revenue financed general hospital operations rather than additional uninsured care.[42] In New Jersey, a study found that uncompensated care's share of hospital revenue rose over the same period, but the authors of that study cautioned that as much as the increase could reflect expanded access, it could also reflect a reduced collection effort from the hospitals now that they were being compensated through the rate-setting system for unpaid care.[40]

Hospital financial stability. Rate setting generally improved hospitals' financial stability by replacing charge volatility and payer-specific negotiation with a predictable, regulated revenue stream. In New Jersey, hospitals that had been running deficits, mostly those serving urban populations with the highest levels of bad debt and charity care, moved from persistent deficits to surpluses comparable to the rest of the state's hospitals.[40] In New York, the pool substantially reduced hospital deficits, cutting private hospital deficits by nearly $100 million in its first year, with public hospitals seeing a smaller improvement of about $20 million.[43] In Maryland, the system had an equalizing effect on hospital earnings and brought

greater year-to-year stability than the national average.[19] Maryland has also consistently had among the highest proportions of investment-grade-rated hospitals of any state.[19]

Capacity to accommodate delivery system change and payment innovation. Critics predicted that rate regulation would be incompatible with the rise of managed care, but Maryland and the Rochester HEPP both were structured to adapt to new payment innovation and both systems experienced substantial growth in health maintenance organizations (HMOs) while their rate-setting systems remained in effect.[33,43] Rate setting also produced several payment innovations that later shaped national policy. For example, Maryland was an early adopter of diagnosis-related-group-based (DRG-based) hospital payment systems, Maryland and the Rochester HEPP pioneered volume adjustment mechanisms to discourage unnecessary volume, and Maryland built pay-for-performance quality incentives into its rate formulas years before Medicare adopted comparable programs nationally.[30]

Some statutes specified the standards, factors, and formulas themselves, which left agencies unable to adjust methods without returning to the legislature and gave the hospital industry a recurring opportunity to seek self-interested amendments.

Why Most Systems Were Abandoned

Six pressures ended these systems: 1) regulatory failure arising from design choices made by states; 2) federal payment policy that gave the most influential hospitals, especially academic medical centers, a reason to leave; 3) state decisions to let HMOs negotiate prices outside the regulated rate structure; 4) an uncompensated care financing mechanism that lacked limits on the amount funded and spread the cost across too few payers; 5) political change and the erosion of the coalition that had sustained these systems; and 6) legal challenges that, although the states ultimately prevailed, created uncertainty about the systems' durability.

Regulatory failure. Regulatory failure in many states arose from some of the design choices or compromises made when the rate-setting statutes were passed. Some statutes specified the standards, factors, and formulas themselves, which left agencies unable to adjust methods without returning to the legislature and gave the hospital industry a recurring opportunity to seek self-interested amendments.[21] Each round of revision added complexity and the repeated tinkering led to incomprehensible and conflicting payment incentives. Incentives that regulated parties cannot comprehend or are inconsistent do not change behavior. Additionally, New Jersey's appeals process allowed a backlog of appeals to accumulate until the rate-setting agency found that adjudicating roughly 2,000 appeals from 85 hospitals was administratively infeasible.[44] Regulators ultimately granted rate increases exceeding $1 billion rather than resolve them.[30] A report by John McDonough reviewing the rise and fall of rate-setting agencies found that officials in states that ended rate setting agreed that the resulting statutes and regulations had become difficult to understand, and participants came to suspect that systems they could not follow were being manipulated by those who could.[21] None of these vulnerabilities were inherent in rate regulation. Less complex and more transparent pricing systems, combined with structural features that protect an agency's independence, can prevent or substantially reduce both regulatory failure and capture.

Federal payment policy changes. A change in federal payment policy also undermined many state rate-setting systems. The Medicare Prospective Payment System (PPS), adopted in 1983 and implemented in 1984, paid hospitals considerably more in its early years than Congress had anticipated, due largely to the adoption of an overly generous payment for graduate medical education.[45] Hospitals in waiver states were excluded from the federal system, so the programs in New York and Massachusetts relinquished their waivers to capture the higher payments offered by federal Medicare payment methods.[21,30,47] Because of

these overpayments by Medicare, state waivers that had made all-payer regulation possible became liabilities to hospitals in states with the highest proportion of Medicare-approved teaching programs.

Exceptions for HMOs. HMOs, which controlled costs by restricting enrollees to a contracted network of providers and negotiating prices with those providers, grew out of the same cost pressures that produced rate setting. As HMOs gained market power in an era of excess hospital capacity, every mandatory rate-setting state had to decide whether HMOs would pay regulated rates or negotiate their own. Massachusetts granted HMOs unlimited discounting authority in 1982 to encourage their growth. At that time, they were less than 2% of the private insurance market, but by 1991, HMOs had become the state's dominant private payer.[21] As a result, public officials had to choose between bringing them under the rate-setting umbrella, a politically challenging task, and letting all plans compete on the same basis. That same year a new governor made hospital deregulation a first-year priority, and deregulation passed overwhelmingly. New York prohibited HMO discounting. However, the practice became common in defiance of the rule, and later versions of the state's rate-setting system authorized the discounts subject to state approval.[22] Overall, the steep discounts that increasingly dominant HMOs extracted from hospitals were an extremely destabilizing force in most rate-setting states, except Maryland, which allowed HMOs to negotiate more affordable per-capita rate arrangements with hospitals as long as they correspondingly reduced hospital costs through active care management.[19,48] Maryland otherwise prohibited HMO discounts that were not associated with reduced hospital costs.

Unconstrained financing of uncompensated care. The financing of uncompensated care was among the reasons hospitals supported rate systems. However, the mechanism that some states built for this purpose undermined the system it was meant to support. Many rate-setting states funded charity care and bad debt through surcharges on regulated rates. New York required hospitals to bill commercially insured patients at the DRG rate plus a 13% surcharge, and for one year a further 11% brought the total to 24% above the DRG rate.[48] New Jersey placed no limit on what hospitals could write off as uncompensated care and gave them little incentive to collect from patients who could pay.[30] This unconstrained pass-through was exacerbated by the expiration of the state's Medicare waiver in 1988, which decreased Medicare revenue in the state by $500 million. These two factors drove uncompensated care above $900 million by 1989 and mechanistically pushed the rate surcharge above 18%.[49] When states exempted HMOs from the surcharge, purchasers could avoid it by moving to HMO plans. This move also shrank the number of people covered by plans paying the surcharge and pushed the rate higher for those who remained subject to state rate setting.[50]

Political change. Political change and the erosion of the coalition that had sustained these systems also contributed to the abandonment of state rate-setting programs.[21] The previously described ad hoc coalition unraveled as the pressures changed what each member had to gain from continued regulation. Hospitals that had advocated for state rate-setting programs to avert the imposition of federal controls now had reason to seek exemption from state systems, since their waivers set payment rates below what Medicare's PPS would pay, and self-insured payers and commercial insurers, which bore the direct cost of rising uncompensated care surcharges, increasingly pushed back against the systems as well.[20] Insurers and employers, which had supported controls to hold down the cost of indemnity coverage, increasingly found coverage more cheaply through HMOs operating outside the regulated rate structure. Legislators and executive officials, who had backed rate setting

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to contain Medicaid costs, joined business groups in preferring market mechanisms as the Reagan administration turned federal policy against regulation, even as many of the same states shifted their own Medicaid programs toward HMOs that sought the same kind of hospital discounts private HMOs did.[21] Republican governors then presided over the final repeals: Massachusetts in 1991, New Jersey in 1992, and New York, in 1997.[21] Electoral shifts, however, were not the primary cause of repeal; they merely finished off a system already weakened by deeper pressures.

Legal challenges. Escalating uncompensated care surcharges, spread over a shrinking base of paying commercial and self-insured plans, drew legal challenges under the Employee Retirement Income Security Act (ERISA). In New Jersey, self-insured union benefit funds sued, arguing the state's uniform hospital surcharge was preempted by ERISA. The district court agreed in 1992, but the Third Circuit reversed the following year.[50] In New York, commercial insurers acting on behalf of self-insured ERISA plans brought a similar challenge, and both the district court and the Second Circuit found the state's surcharges preempted.[49] The Supreme Court resolved the conflict in *Blue Cross v. Travelers*, holding that surcharges with only an indirect economic effect on the relative cost of insurance do not "relate to" employee benefit plans within the meaning of ERISA § 514(a), and therefore are not preempted.[49] The states ultimately prevailed, but years of litigation-related uncertainty accelerated the move toward deregulation.

Where other states locked methodology into statute, Maryland's enabling legislation gave the HSCRC the overarching goals of solvency, efficiency, equity, and access, but left the methodology for achieving them to the agency.

Why Maryland Survived

By avoiding each of the six pressures that ended rate setting elsewhere, Maryland's rate-setting system outlasted the other systems by many decades. Maryland avoided regulatory failure primarily through its enabling legislation and formulaic approach to rate setting.[51] Where other states locked methodology into statute, Maryland's enabling legislation gave the HSCRC the overarching goals of solvency, efficiency, equity, and access, but left the methodology for achieving them to the agency.[52] As a result, the HSCRC could revise its approach without returning to the legislature for each change.[53] Where some other states relied on contentious annual budget reviews, the HSCRC updated hospital rates through formulas, which reduced the opportunities for the kind of gaming and conflict that undermined other systems. The formulas were stable for a long time and were logical and well understood by the industry.[21,30]

As a result, the commission set clear incentives that hospitals could respond to, and through the early 1990s, the incentives did not provoke the kind of industry backlash that destabilized other states' systems.[30] Maryland maintained its waiver through the change in federal payment policy that caused other states to abandon theirs. When Maryland negotiated its waiver in 1977, Medicare payments to Maryland hospitals were already about 30% above the national average, and the waiver allowed the state to retain those higher payments as long as Maryland's Medicare payments per case grew more slowly, on a cumulative basis, than Medicare payments per case nationally.[30] The enhanced revenue from Medicare to Maryland hospitals made the waiver "the linchpin for the system and a galvanizing force for all stakeholders."[19,52] Where HMOs eroded the surcharge base elsewhere, Maryland's all-payer statute applied to all payers without exemption, resulting in a smaller surcharge for uncompensated care funding because it was spread across the broadest revenue base possible.[19]

Where uncompensated care financing destabilized other states' surcharge mechanisms, the HSCRC-approved rates carried a uniform uncompensated care funding provision of roughly 8%, so all payers contributed to that cost through the same rate every payer faced.[53] The HSCRC also capped what hospitals could recover for uncompensated care, paying each hospital the lower of its actual uncompensated care percentage or a predicted amount calculated from patient and neighborhood characteristics, which gave hospitals an incentive to collect bad debt rather than pass rising costs through to rates.[53] Finally, where the coalition that had sustained other states' systems broke apart as members' interests diverged, Maryland's coalition held together, anchored by the enhanced payments Maryland received under its Medicare waiver. The waiver's federal payments were valuable enough that no member of the coalition wanted to risk triggering federal reconsideration of the waiver itself.[19,52]

The system also evolved rather than remaining stagnant. In the late 1990s the HSCRC crafted a policy to allow HMOs to be successful and grow if they were able to reduce costs by managing hospital care, rather than extracting discounts through market power; experimented with global budgets for rural hospitals; and introduced the volume adjustment system to curtail unnecessary volume. In 2014, Maryland and the Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) replaced the per-case payment model with a global hospital budget model, constraining the growth of each hospital's total revenue rather than the amount paid per admission.[53] The model reduced Medicare spending, but the strong incentive of fixed global budgets to limit hospital use also produced a measurable increase in emergency department boarding and ambulance diversion.[54,55]

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WHAT WORKED AND WHAT DIDN'T: FOUR LESSONS FROM PREVIOUS STATE RATE-SETTING SYSTEMS

A comparison across the systems points to specific design choices that separated the states with systems that worked from the states with systems that did not. Washington is the sharpest comparison with Maryland, since its enabling statute and Medicare waiver closely mirrored Maryland's, yet its system collapsed within 15 years while Maryland's persists today.[30] The Rochester system, operating as a regional demonstration rather than a full state system, adopted many of the same design choices as Maryland and achieved comparable success, suggesting the results were tied to those choices rather than to something particular to Maryland itself. Across the rate-setting systems implemented in the early 1970s and 1980s, four differences in design and administration account for much of the divergence in outcomes.

Lesson 1: Macro-Level, Formula-Based Updates Beat Line-Item Annual Budget Reviews

Although Maryland and Washington began with nearly identically broad enabling statutes, they chose opposite methods for both establishing and updating rates, and the results diverged sharply. Washington relied on a detailed annual line-item review in which rate-setting staff evaluated each hospital's cost budget and approved or disapproved costs center

by center, an approach that effectively passed through hospitals' operating cost increases. Even though the resulting rate increases were generous and exceeded the national average over the period of regulation, the hospital industry found the reviews intrusive and time consuming, and Washington's own legislative sunset review found that hospital cost growth in the state exceeded the national average and that of five other regulated states between 1981 and 1986.[56]

Conversely, Maryland and Rochester set initial rates from hospitals' historical costs, then updated them more gradually by formula, fixing payment levels and placing hospitals at financial risk for controlling their costs. This contrasted with Washington's micro-regulatory approach, which included a detailed annual review and questioning of each line item cost that a hospital reported. Maryland's and Rochester's formula-based updates rewarded hospitals that controlled costs with rate increases they could keep as profit and treated hospitals that missed targets as outliers subject to closer scrutiny and rate reductions, without instructing all hospital managers on how to run their institutions. Washington's line-item review had the opposite effect, substituting regulators' judgment for that of hospital administrators on individual cost decisions.

Lesson 2: Broad Delegation to Agency Beats Detailed Legislation

New York, New Jersey, and Massachusetts wrote their rate-setting formulas directly into their statutes rather than delegating the formula to the regulating agency, and the consequences compounded over time.[21] Because these legislatures had to revise the statute itself every two to three years to respond to changed conditions or hospital complaints, each revision gave the hospital industry a fresh opportunity to press for amendments that benefited their interests. Each successive round of amendments undermined the consistency of payment methods and left the systems too complex for hospitals, insurers, or regulators to understand.[30] The former chairman of the Massachusetts Senate Health Committee said the statutes were "like Sanskrit — no one could understand them, even the hospital people," and one contemporary study found that the complexity of New York's rate methodology was "the source of considerable black humor within the state."[21] This confusion fed suspicion that the systems were being gamed by powerful players (particularly the teaching and urban hospitals that benefited disproportionately from their redistributive features), and complaints from less influential hospitals led legislators and regulators to make a series of adjustments that generally left the systems even less comprehensible.

Maryland avoided this pattern. Its enabling statute, largely unaltered since 1971, differs from most of the others in its simplicity and in the breadth of authority it delegates to the HSCRC, which has used that autonomy to pursue its core goals of cost control, payer equity, health care access, and institutional stability while experimenting with alternative payment methods.[21]

Lesson 3: Limit Appeals to Minimize Gaming

New Jersey's experience shows the danger of an appeals process a regulator cannot administratively control. The state created a process allowing hospitals to seek relief from rate limits for cost increases outside their control, such as nursing shortages and the AIDS epidemic of the time, but the process drew roughly 2,000 appeals from the state's 85 hospitals and produced a backlog the agency could not resolve individually.[57] Rather

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than adjudicate the appeals, regulators "threw up their hands" and granted hospitals rate increases in excess of $1 billion to settle the outstanding requests.[20, 21]

Maryland and West Virginia avoided this regulatory failure by structuring appeals so that a hospital that requested a rate review in either state could see its rates lowered, not just raised, if the commission concluded on adjudication that a lower rate was more reasonable. This risk meant hospitals had a real reason to appeal only when they had a substantiated claim.[20] Maryland also placed the burden of proof on the hospital in any appeal; set strict time frames and deadlines for the filing of, review of, and ruling on appeals; and eliminated any additional administrative appeal beyond the commission (i.e., after a commission ruling, hospitals had to appeal directly to the courts).

The 1970s and 1980s systems demonstrated that mandatory rate regulation can restrain the growth of hospital spending without destabilizing hospital finances.

Lesson 4: Agency Funding, Staff Expertise, and Stable Leadership Are the Foundations of Effective Regulation

Maryland, Rochester, and Washington all funded their agencies the same way, through fees assessed on hospital rates, so funding mechanism alone does not explain why Washington's rate system was less effective than the ones in Maryland and Rochester. One key difference was the expertise of the people running each system.[30] Maryland's first executive director was an expert in regulatory economics, and its deputy director, a mathematician by training, designed the formula-based and incentive-based methods that the same deputy director then brought to Rochester as a consultant.[30] Washington's commission, by contrast, operated with fewer than 20 full-time staff serving nine part-time volunteer commissioners, and interviews with former commissioners indicate the state's salary structure could not attract expertise comparable to the original HSCRC staff. One former commissioner described the result as a "cheap imitation" of the Maryland system consistently outmatched by the hospital industry and its consultants and lacking the resolve, leadership, political support, and funding necessary to implement a rigorous and successful system.[30]

A STEPWISE PATH FOR STATES TODAY

The 1970s and 1980s systems demonstrated that mandatory rate regulation can restrain the growth of hospital spending without destabilizing hospital finances. At the time, cost-based reimbursement generated inflation through its design and there was nothing to constrain prices or spending. Prices now rise because consolidated hospital systems have the market power to raise them and commercial insurers lack the leverage to refuse. The price increases from cost-based reimbursement are a failure of payment design. The price increases from consolidation are a failure of market structure. Either failure produces the same result: health spending that grows faster than the economy, crowds out investment in education and infrastructure, and makes hospital care unaffordable for individuals, families, and workers.[58] Employer premiums function as a regressive head tax that falls hardest on lower- and middle-income workers, exacerbating income inequality.[59] Hospital price increases from mergers have been linked to higher unemployment and reduced tax revenue.[3] These consequences are the direct product of exorbitantly high prices, driven by the market power of highly consolidated hospitals and hospital systems, which states have both the precedent and the reason to constrain through government-administered rate setting.

States can act to pass legislation that sets up an independent rate-setting commission immediately or choose a stepwise approach, in which each step builds political coalitions, regulatory infrastructure and expertise, and data systems useful for the next step. The rest of this section describes such a stepwise development plan. No step in this sequence is required, and a state may proceed directly to any later step without first having implemented the ones that precede it. States should be cautious about overly refining each step before advancing to the next one, since every year spent perfecting one stage is a year in which hospital prices continue to rise unconstrained.

Demonstrable evidence that rate setting can save states and patients money can bolster support and blunt the objections hospitals are likely to raise against a more comprehensive cap later.

Step 1: Lower-Intensity, Partial-Market Options

Before committing to comprehensive rate regulation, a state can adopt one or more lower-intensity measures that reach only part of the commercial market. Each of the three options below can be adopted alone or in combination, and any of them enable a state to build regulatory expertise, compile hospital cost data, and develop a track record of savings without disrupting hospital finances. Demonstrable evidence that rate setting can save states and patients money can bolster support and blunt the objections hospitals are likely to raise against a more comprehensive cap later.

Option A: Cap What the State Employee Health Plan Pays Hospitals

A state can direct its employee health plan, whether self-administered or run through a contracted third-party administrator, to cap hospital payments at a set level, typically expressed as a percentage of Medicare rates.[12] This approach requires no new legislation or agency, since the state is using its existing authority as a purchaser. However, the resulting cap can be vulnerable to a hospital simply refusing to accept it and depends on the plan administrator's willingness to hold the line. Montana adopted this approach administratively in 2016 and saved an estimated $48 million over three fiscal years, but the program was weakened in 2022 after a change in plan administrator.[60,61] States that want a more durable cap can instead set it by statute, as Oregon and Washington have done and a growing number of other states are considering.[61-64,62]

Option B: Extend Medicare-Benchmarked Caps to Public Option and Marketplace Plans

A state can require insurers offering marketplace plans to cap what they pay hospitals, benchmarked to Medicare, as a condition of participating in a state-sponsored public option. Washington's Cascade Care and Colorado's public option both set hospital reimbursement targets benchmarked to Medicare for insurers offering standardized plans on the state exchange.[63,64,65] Whether hospitals must participate appears key to the success of these plans. Washington initially relied on voluntary hospital participation, and much of the state had no public option plan available in the program's first year. So the legislature later required hospitals that accept Medicaid or state public employee benefits to contract with at least one Cascade Select plan.[66,67] Colorado authorizes the state Division of Insurance to hold a public hearing and set hospital reimbursement rates directly if an insurer offering the public option plan cannot negotiate a network that meets the plan's premium reduction or network adequacy requirements.[70] That backstop authority caused the state to meet its premium

targets without ever needing to use the rate-setting authority; the threat of a hearing appeared to be enough to bring hospitals to the table.[68,69]

Medicare-benchmarked caps in public option plans reach only the individual and small group markets sold through the state exchange, which is a small share of the overall commercial market. As a result, the direct effect of these caps on hospital prices is likely to be modest, though it may place some competitive pressure on other commercial plans if the public option's lower premium forces them to compete on price.[70] The greater value of these plans is establishing precedent for a Medicare-benchmarked reimbursement formula and, in Colorado's case, an enforcement mechanism the state can use if hospitals refuse to negotiate.

Option C: Cap Out-of-Network Payments for the Commercial Market

Rather than limiting an out-of-network cap to a single plan, as Step 1 does for the state employee plan, a state can set a cap for all commercial payers statewide. The federal No Surprises Act might seem to do this, but it applies only to emergency care and non-emergency care by out-of-network providers at in-network facilities, and its arbitration process for resolving what insurers owe providers has faced extensive litigation, resulted in a huge number of disputes, and produced very high awards for health care providers.[71,72] No state has yet enacted a payment cap that applies to out-of-network payments across the entire commercial market. Because out-of-network care is a small share of total hospital revenue, this step likely draws less hospital opposition than a market-wide cap on all payments, while improving insurers' in-network negotiating leverage, since a hospital that walks away from a contract knows the insurer will pay no more than the state cap.

Step 2: Establish Hospital Payment Caps for All Commercial Payers

The options above reach only part of the commercial market: a single payer, a subset of plans, or out-of-network claims. A broader and more effective approach that a state could take legislatively is to set a payment cap that reaches every commercial payer by limiting the amount a hospital can charge and must accept for full payment for all health care services. In 2025, Vermont and Indiana became the first states to enact this kind of cap. Vermont's Act 68 directs the Green Mountain Care Board to set reference-based price caps representing the maximum amounts Vermont hospitals may accept as payment in full for services delivered in the state, benchmarked to Medicare, with global hospital budgets to follow for non-critical-access hospitals by FY2027 and for all hospitals by FY2030.[73] Indiana's HB 1004 requires nonprofit hospital systems with at least $2 billion in Indiana patient service revenue, currently the largest five, to bring aggregate average inpatient and outpatient prices to or below a statewide average by June 30, 2029, or forfeit state tax-exempt status for at least one year. The law separately requires those systems to offer employers direct contracts with rates at or below 260% of full Medicare beginning September 1, 2025, and extending to all other hospitals in 2026.[74] Both laws share the design feature that makes a market-wide cap possible without running into ERISA preemption and cap what a hospital may charge and accept as payment in full, rather than what an insurer must pay.

Neither law, however, creates the kind of standing rate commission that operated in Maryland and the 1970s and 1980s systems. Vermont comes closer, since the Green Mountain Care Board is an existing independent agency with institutional capacity and public deliberation processes built in, but its price caps do not fully phase in until FY2030. Indiana's

A broader and more effective approach that a state could take legislatively is to set a payment cap that reaches every commercial payer by limiting the amount a hospital can charge and must accept for full payment for all health care services.

law relies on the threat of losing nonprofit tax status rather than an agency with ongoing authority to set, review, or adjust rates once the target is met.

A public-utility-style commission trades the apparent speed and simplicity of rate caps for something much more durable and responsive to market conditions. When setting rates per individual hospital service, rather than caps, commissions can also meet other important policy goals that earlier rate-setting systems achieved: payment equity and access, hospital financial stability, and the capacity to accommodate delivery system change and payment innovation. Implementation of rate controls per hospital service (i.e., setting both a ceiling and a floor) allows a rate-setting commission to more effectively reduce payment inequities across the system, adopt volume adjustments that reduce payments if hospitals increase volumes in response to payment limits, or increase payment levels to provide financial stability to rural hospitals or other facilities with high fixed costs if volumes drop. A state adopting this approach can establish set rates for all covered hospitals that are initially near existing payment levels and phase them down to a benchmark over time. Reducing rates over time is particularly important if the state also aims to stabilize hospitals already in financial distress, since an abrupt, deep cut to their revenue could destabilize the same facilities a rate-setting system is meant to protect.

When setting rates per individual hospital service, rather than caps, commissions can also meet other important policy goals that earlier rate-setting systems achieved: payment equity and access, hospital financial stability, and the capacity to accommodate delivery system change and payment innovation.

Step 3: Pursue a CMS Waiver for All-Payer Adjustable (Flexible) Global Budgets

The final step folds Medicare and Medicaid into the state's rate-setting system, producing a true all-payer model like Maryland's. This step requires federal cooperation, since Medicare and Medicaid payment rates are set under federal law. Maryland's original 1970s system regulated commercial payers directly under state authority but brought in Medicare through a specific waiver, then codified at 42 U.S.C. § 1395f(b)(3).[20] When Maryland moved to a global-budget model in 2014, it permanently relinquished that statutory waiver in exchange for a model agreement under a Section 1115A waiver, which lets the CMMI test payment models directly with a state through a negotiated agreement waiving specific Medicare requirements as needed, rather than a stand-alone statutory waiver.[75] Maryland's current Achieving Healthcare Efficiency through Accountable Design (AHEAD) agreement rests on the same authority, so the state's Medicare participation now depends on the cost containment and other terms of a CMMI model rather than on a statutory exemption.

After a state secures a waiver or agreement from CMS, it should consider setting a *flexible global budget* for each hospital in the state. A fixed global budget gives a hospital a set amount of revenue for the year no matter how many patients it treats. The fixed budget removes the incentive to deliver unnecessary care, but it also gives hospitals extremely strong financial incentives to reduce capacity and staffing and actively stint on care, since their revenue is capped regardless of how many patients they serve.[76,77] *A flexible global* budget avoids these maladies by adjusting the hospital's total revenue during the year to reflect actual volume and case mix, and it gives the hospital no incentive to stint on care, since its revenue rises and falls with the incremental cost it incurs to treat new patients.[78]

This approach also gives the rate-setting agency the ability to raise the budgets of rural and safety-net hospitals that struggle with low volume, high fixed costs, and a high share of public payers, and to do so across every payer at once rather than through a patchwork of payer-specific supplements. Global budgets work best in an all-payer rate-setting system, with each

payer contributing fairly to fund each hospital budget. A budget applied to some payers while others, like Medicare and Medicaid, remain based on fee-for-service creates conflicting incentives and encourages the hospital to shift volume or costs toward whichever payer rewards it the most for doing so.

States do not need to build a new solution from scratch, nor do they need to attempt to build the whole system at once.

CONCLUSION: THE CASE FOR ACTING NOW AND THE COST OF WAITING

The historical record clearly shows that governments can regulate hospital prices and improve cost containment without destabilizing hospital finances or patient access. Rate-setting systems in New York, New Jersey, Massachusetts, and Washington did so for a decade or more, and Maryland's has done so for five. When systems failed, they failed for identifiable and avoidable reasons, including rigid statutory methodology, inadequate agency funding and expertise, and eroding political coalitions, not because rate regulation itself does not work.

The market failure that rate setting was built to correct in the 1970s has reemerged in a different form. The 20th-century cost-based reimbursement created a financing system that allowed hospitals to increase their costs without constraint; the current consolidated market power lets them set prices commercial insurers lack the leverage to refuse. In both cases, price is set by something other than a competitive market, and the same regulatory solutions can be implemented to address either set of market distortions.

States do not need to build a new solution from scratch, nor do they need to attempt to build the whole system at once. The stepwise path this paper describes lets a state build the coalitions, data infrastructure, and regulatory capacity a comprehensive system requires while realizing savings at each stage along the way. The technical and legal groundwork is already established, and there is growing interest and urgency at the state level to apply past successful regulatory approaches to the hospital sector to rein in exorbitant prices and unaffordable spending on hospital care. What remains is the same thing that was required in the 1970s: the political will to act before the next decade of unconstrained hospital price growth makes the problem larger than the one states solved before.

NOTES

1. Godwin J, Levinson Z, Neuman T. One or two health systems controlled the entire market for inpatient hospital care in nearly half of metropolitan areas in 2024. KFF website. www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas/. Published March 27, 2026. Accessed September 18, 2026.

2. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? Hospital prices and health spending on the privately insured. *Q J Econ*. 2019;134(1):51-107.

3. Brot-Goldberg Z, Cooper Z, Craig SV, Klarnet LR, Lurie I, Miller CL. *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers*. NBER Working Paper No. 32613. Cambridge, MA: National Bureau of Economic Research; 2024. doi:10.3386/w32613.

4. Havighurst CC, Richman BD. The provider monopoly problem in health care. *Oreg Law Rev*. 2011;89(3):847-884.

5. Town RJ, Wholey D, Feldman R, Burns LR. Revisiting the relationship between managed care and hospital consolidation. *Health Serv Res*. 2007;42(1 pt 1):219-238. doi:10.1111/j.1475-6773.2006.00601.x.

6. Posner RA. *Antitrust Law*. 2nd ed. Chicago, IL: University of Chicago Press; 2001.

7. Congressional Budget Office. *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*. Washington, DC: Congressional Budget Office; 2022. www.cbo.gov/publication/58541. Accessed September 18, 2026.

8. Einav L, Finkelstein A, Ji Y, Mahoney N. Voluntary regulation: Evidence from Medicare payment reform. *Q J Econ*. 2022;137(1):565-618.

9. Joskow PL. Regulation of natural monopoly. *In: Handbook of Law and Economics*. Vol 2. Polinsky AM, Shavell S, eds. Amsterdam, the Netherlands: Elsevier; 2007. doi:10.1016/S1574-0730(07)02016-6.

10. Bagley N. Medicine as a public calling. *Mich Law Rev*. 2015;114(1):57-106.

11. Manchikanti L, Helm S II, Benyamin RM, Hirsch JA. Evolution of US health care reform *Pain Physician*. 2017;20(3):107-110.

12. National Academy for State Health Policy. Overview of states' hospital reference-based pricing to Medicare initiatives. NASHP website. nashp.org/state-tracker/overview-of-states-hospital-reference-based-pricing-to-medicare-initiatives/. Published August 3, 2026. Accessed September 18, 2026.

13. Weiner SM. "Reasonable cost" reimbursement for inpatient hospital services under Medicare and Medicaid: the emergence of public control. *Am J Law Med*. 1977;3(1):1-47. doi:10.1017/S0098858800012788.

14. Feldstein PJ, Waldman S. Financial position of hospitals in the early Medicare period. *Soc Secur Bull*. 1968;31(10):18-23. www.ssa.gov/policy/docs/ssb/v31n10/v31n10p18.pdf. Accessed September 18, 2026.

15. Tompkins CP, Altman SH, Eilat E. The precarious pricing system for hospital services. *Health Aff (Millwood)*. 2006;25(1):45-56. doi:10.1377/hlthaff.25.1.45.

16. Moseley GB III. The U.S. health care non-system, 1908-2008. *AMA J Ethics*. 2008;10(5):324-331. doi:10.1001/virtualmentor.2008.10.5.mhst1-0805.

17. Somers HM, Somers AR. *Medicare and the Hospitals: Issues and Prospects*. Washington, DC: Brookings Institution; 1967. https://archive.org/details/medicarehospital0000herm.

18. National Center for Health Statistics. *Health, United States, 2016: With Chartbook on Long-term Trends in Health*. Hyattsville, MD: National Center for Health Statistics; 2017. Table 94.

19. Murray R. Setting hospital rates to control costs and boost quality: the Maryland experience. *Health Aff (Millwood)*. 2009;28(5):1395-1405. doi:10.1377/hlthaff.28.5.1395.

20. Murray R, Berenson RA. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* Washington, DC: Urban Institute; 2015. www.urban.org/research/publication/hospital-rate-setting-revisited-dumb-price-fixing-or-smart-solution-provider-pricing-power-and-delivery-reform. Accessed September 18, 2026.

21. McDonough JE. Tracking the demise of state hospital rate setting. *Health Aff (Millwood)*. 1997;16(1):142-149. doi:10.1377/hlthaff.16.1.142.

22. Kahn AE. *The Economics of Regulation: Principles and Institutions*. Vol 1. *Economic Principles*. New York: John Wiley & Sons; 1970.

23. Chernew M, Cooper Z, Larsen Hallock E, Scott Morton F. Physician agency, consumerism, and the consumption of lower-limb MRI scans. *J Health Econ*. 2021;76:102427. doi:10.1016/j.jhealeco.2021.102427.

24. U.S. General Accounting Office. *Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Management*. Publication HRD-80-72. Washington, DC: U.S. General Accounting Office; 1980.

25. Maryland Health Services Cost Review Commission. HSCRC overview. HSCRC website. hscrc.maryland.gov/Pages/About-Us.aspx. Accessed September 18, 2026.

26. Social Security Amendments of 1972, Pub L No. 92-603, §222, 86 Stat 1329, 1391 (1972).

27. National Health Planning and Resources Development Act of 1974, Pub L No. 93-641, 88 Stat 2225 (1975).

[28] Social Security Amendments of 1983, Pub L No. 98-21, §601, 97 Stat 65, 149 (1983) (codified at 42 U.S.C. §1395ww).

[29] Sloan FA. Rate regulation as a strategy for hospital cost control: evidence from the last decade. *Milbank Mem Fund Q Health Soc*. 1983;61(2):195-221. www.milbank.org/quarterly/articles/rate-regulation-as-a-strategy-for-hospital-cost-control-evidence-from-the-last-decade/.

[30] Murray RB, Gudiksen KL. *U.S. State-Based Hospital Rate Setting: What Worked, What Didn't, and What We Need to Do Now*. San Francisco, CA: The Source on Healthcare Price and Competition; 2024. sourceonhealthcare.org/wp-content/uploads/2024/12/The-Source-US-State-Based-Hospital-Rate-Setting.pdf. Accessed September 18, 2026.

[31] Friedman B, Wong HS. Impacts of hospital budget limits in Rochester, New York. *Health Care Financ Rev*. 1995;16(4):201-219.

[32] Block JA, Regenstreif DI, Griner PF. A community hospital payment experiment outperforms national experience: the Hospital Experimental Payment Program in Rochester, NY. *JAMA*. 1987;257(2):193-197. doi:10.1001/jama.1987.03390020059027.

[33] Hall WJ, Griner PF. Cost-effective health care: the Rochester experience. *Health Aff (Millwood)*. 1993;12(1):58-69. doi:10.1377/hlthaff.12.1.58.

[34] West Virginia Health Care Authority. Rate review history. West Virginia Health Care Authority website. hca.wv.gov/ratereview/Pages/RR_History.aspx. Accessed August 21, 2026.

[35] Schramm CJ, Renn SC, Biles B. Controlling hospital cost inflation: new perspectives on state rate setting. *Health Aff (Millwood)*. 1986;5(3):22-33. doi:10.1377/hlthaff.5.3.22.

[36] Robinson JC, Luft HS. Competition, regulation, and hospital costs, 1982 to 1986. *JAMA*. 1988;260(18):2676-2681. doi:10.1001/jama.1988.03410180084034.

[37] Md. Ann. Code art. 43, § 568H et seq. (Supp. 1975).

[38] Wash. Rev. Code Ann. § 70.39.010 et seq. (2026).

[39] Hsiao WC, Sapolsky HM, Dunn DL, Weiner SL. Lessons of the New Jersey DRG payment system. *Health Aff (Millwood)*. 1986;5(2):32-45. doi:10.1377/hlthaff.5.2.32.

[40] Thorpe KE. Does all-payer rate setting work? The case of the New York Prospective Hospital Reimbursement Methodology. *J Health Polit Policy Law*. 1987;12(3):391-408. doi:10.1215/03616878-12-3-391.

[41] Maryland Health Services Cost Review Commission, Final Hospital Uncompensated Care Policy Report (November 3, 2025), https://hscrc.maryland.gov/Documents/November%202025%20PUBLIC%20PREMEETING%20-%20finalv3.pdf. ccessed September 21, 2026.

[42] Thorpe KE. Uncompensated care pools and care to the uninsured: lessons from the New York Prospective Hospital Reimbursement Methodology. *Inquiry*. 1988;25(3):344-353.

[43] McDonough JE. *Interests, Ideas, and Deregulation: The Fate of Hospital Rate Setting*. Ann Arbor, MI: University of Michigan Press; 1997.

[44] Murray R. *Rate Regulation Revisited: Managing Regulatory Failure and Regulatory Capture in Health Care*. New York: Milbank Memorial Fund; 2022.

[45] Guterman S, Altman SH, Young DA. Hospitals' financial performance in the first five years of PPS. *Health Aff (Millwood)*. 1990;9(1):125-134. doi:10.1377/hlthaff.9.1.125.

[46] Social Security Act §1814(b)(3), 42 U.S.C. §1395f(b)(3) and Social Security Act §1886(c), 42 U.S.C. §1395ww(c).

[47] Maryland Hospital Association. *Achievement, Access, and Accountability: Maryland's All-Payor Hospital Payment System*. Elkridge, MD: Maryland Hospital Association; 2007. hscrc.maryland.gov/Documents/pdr/GeneralInformation/AshbyReport2007.pdf. Accessed September 21, 2026.

[48] *New York State Conference of Blue Cross & Blue Shield Plans v Travelers Insurance Co*, 514 US 645 (1995).

[49] Clemens J, Ippolito B. Uncompensated care and the collapse of hospital payment regulation: an illustration of the Tinbergen rule. *Public Finance Rev*. 2019;47(6):1002-1041. doi:10.1177/1091142119871333.

[50] *United Wire, Metal & Machine Health & Welfare Fund v Morristown Memorial Hospital*, 793 F Supp 524 (DNJ 1992), rev'd, 995 F2d 1179 (3d Cir 1993), cert denied, 510 US 944 (1993).

[51] Pope C. *When Government Sets Hospital Prices: Maryland's Experience*. New York: Manhattan Institute; 2019. manhattan.institute/article/when-government-sets-hospital-prices-marylands-experience. Accessed September 18, 2026.

[52] Cohen HA. *Maryland's All-payor Hospital Payment System*. Baltimore, MD: Maryland Health Services Cost Review Commission. hscrc.maryland.gov/documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf. Accessed September 18, 2026.

[53] Anderson GF. All-payer ratesetting: down but not out. *Health Care Financ Rev*. 1991;(suppl):35-41.

[54] Stryckman B, Kuhn D, Gingold DB, et al. Balancing efficiency and access: discouraging emergency department boarding in a global budget system. *West J Emerg Med*. 2021;22(5):1196-1201. doi:10.5811/westjem.2021.5.51889.

[55] Haber S, Beil H, Morrison M, et al. *Evaluation of the Maryland All-Payer Model, Volume I: Final Report*. Waltham, MA: RTI International; 2019. downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf. Accessed September 18, 2026.

[56] Washington State Senate Committee on Ways & Means. *Senate Bill Report: SB 5385*. Olympia, WA: Washington State Legislature; 1989. lawfilesext.leg.wa.gov/Law/1989-90/Htm/Bill%20Reports/Senate/5385.SBR.htm. Accessed September 18, 2026.

[57] Volpp KG, Siegel B. New Jersey: long-term experience with all-payer state rate setting. *Health Aff (Millwood)*. 1993;12(2):59-65. doi:10.1377/hlthaff.12.2.59.

[58] Murray RB, Gudiksen KL. *"Americans Always Do the Right Thing": When Will the U.S. Finally Control Runaway Hospital Price Growth?* San Francisco, CA: The Source on Healthcare Price and Competition; 2024. sourceonhealthcare.org/profile/americans-always-do-the-right-thing-when-will-the-u-s-finally-control-runaway-hospital-price-growth/. Accessed September 18, 2026.

[59] Finkelstein A, McQuillan C, Zidar O, Zwick E. The health wedge and labor market inequality. *Brookings Pap Econ Act*. 2023;(Spring):425-503. doi:10.1353/eca.2023.a919363.

[60] Houghton K. Montana backs away from innovative public employee health plan. *Governing*. October 30, 2022. www.governing.com/now/montana-backs-away-from-innovative-public-employee-health-plan. Accessed September 18, 2026.

[61] Schramm S, Aters Z. *Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan*. Washington, DC: National Academy for State Health Policy; 2021. www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf. Accessed September 18, 2026.

[62] Murray RC, Whaley CM. Commercial prices relative to Medicare were lower under an employer-based reference pricing program. *Health Aff Sch*. 2026;4(7):qxag156. doi:10.1093/haschl/qxag156.

[63] State Hub for Hospital Pricing Strategies. Hospital price caps. hospitalpricingstatehub.org/pricing-strategy/hospital-price-caps/. Accessed September 18, 2026.

[64] Colorado Option is Reducing Hospital Prices and Saving Coloradans Money: https://doi.colorado.gov/news-releases-consumer-advisories/colorado-option-is-reducing-hospital-prices-and-saving-coloradans. September 1, 2026. Accessed September 18, 2026.

[65] Colorado Hospital Association. *Issue Brief: House Bill 21-1232, Standardized Health Benefit Plan Colorado Option*. Denver: Colorado Hospital Association; 2021. cha.com/wp-content/uploads/2021/07/Colorado-Option_final.pdf. Accessed September 18, 2026.

[66] Carlton S, Kahn J, Lee M. Cascade Select: insights from Washington's public option. *Health Affairs Forefront*. August 30, 2021. doi:10.1377/forefront.20210819.347789.

[67] Health Care Value Hub. 2024 health care affordability state policy snapshot: Washington. healthcarevaluehub.org/wp-content/uploads/Washington_Snapshot.pdf. Accessed September 18, 2026.

[68] Murray RC, Whaley CM. Can public option plans improve affordability? Insights from Colorado. *Health Affairs Forefront*. January 15, 2025. doi:10.1377/forefront.20250113.844529.

[69] Pohl RV, Steiner A, Lazaro Davadi M, et al. *Analysis of the Colorado Option, Pursuant to § 10-16-1310, C.R.S.* Princeton, NJ: Mathematica; 2026. www.mathematica.org/publications/analysis-of-the-colorado-option. Accessed September 18, 2026.

[70] Rakshit S, Ortaliza J, Cotter L, Rae M, Cox C. Recent trends in commercial health insurance market concentration. Peterson-KFF Health System Tracker website. www.healthsystemtracker.org/chart-collection/recent-trends-in-commercial-health-insurance-market-concentration/. Published December 11, 2025. Accessed September 18, 2026.

[71] Congressional Research Service. *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*. Report R48738. Washington, DC: Congressional Research Service; 2025. www.congress.gov/crs-product/R48738. Accessed September 18, 2026.

[72] Hoadley J, Watts K, Keith K, DeGarmo E. The No Surprises Act IDR process: an early look at 2025 data. *Health Affairs Forefront*. March 20, 2026. www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data.

[73] Green Mountain Care Board. Hospital reference-based pricing. Green Mountain Care Board website. gmcboard.vermont.gov/hospital-reference-based-pricing. Accessed September 18, 2026.

[74] Galewitz P. Indiana caps prices hospitals charge employers, with tax exemptions on the line. *KFF Health News*. June 26, 2026. kffhealthnews.org/health-industry/the-week-in-brief-indiana-hospital-price-controls/. Accessed September 18, 2026.

[75] Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. CMS website. www.cms.gov/priorities/innovation/innovation-models/md-tccm. Accessed September 18, 2026.

[76] Jain A, Aggarwal S, Aziz K, Polsky D. Beyond the global budget: Maryland's next chapter must engage clinicians. *Health Affairs Forefront*. April 6, 2026. www.healthaffairs.org/content/forefront/beyond-global-budget-maryland-s-next-chapter-must-engage-clinicians. Accessed September 21, 2026.

[77] Bulat T, McClellan SR, Trombley MJ. Under global budgets, hospital utilization in Maryland decreased by 11 percentage points more than in other states, 2013-23. *Health Aff (Millwood)*. 2026;45(4):378-386. doi:10.1377/hlthaff.2025.01324.

[78] Murray R. *Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending*. New York: Commonwealth Fund; 2022. www.commonwealthfund.org/publications/issue-briefs/2022/mar/hospital-global-budgets-state-tool-controlling-spending. Accessed September 18, 2026.

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