# How States Are Using Hospital Price Caps To Save Money

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Health care costs are rapidly increasing. The burden of these costs falls on patients in the form of higher premiums and cost sharing—consuming a growing share of families' budgets. The burden also falls on state governments, which are facing increased budgetary pressures due to more expensive state employee health plans. And state budgets are only going to become more constrained as the provisions of the federal reconciliation act go into effect, including caps on states' ability to use provider taxes to fund their Medicaid programs.

Research has shown that hospital prices are the largest driver of increases in commercial health care spending. Hospital markets are highly concentrated, and more than half of all physicians are employed by hospitals. This consolidation has allowed hospitals to charge higher prices, without corresponding improvements in quality or outcomes.

To address high and rising hospital prices, states have taken a variety of approaches to address consolidation in their health care sectors. This year, states have strengthened their review authority for large-scale health care transactions (see New Mexico), mandated the disclosure of ownership interests in providers (see Indiana), and strengthened restrictions on corporate ownership of medical practices (see Oregon).

In addition, states have increasingly been interested in instituting hospital price controls, both to limit price increases resulting from consolidation and to discourage future consolidation. Some states have enacted hospital price controls solely for their state employee health plans, as a means to save money for state budgets and state employees. But other states have gone even further, establishing hospital price controls across the entire market, for both state employee health plans and commercial markets.

## Price Caps In State Employee Health Plans

In response to budgetary pressures, Oregon enacted legislation in 2017 to cap the amount that the state's employee health plan would pay hospitals at 200 percent of Medicare rates for in-network services and 185 percent for out-of-network services. That policy has achieved these goals, saving the state of Oregon around $50 million annually since its implementation. To date, all 24 hospitals that were in the plan's network prior to the policy have remained in-network—likely incentivized by the policy's lower cap for

out-of-network providers. This policy did not lead to higher prices among the non-state employee commercial market. Another study found that the policy led to a 9.5 percent reduction in hospital out-of-pocket spending for state employees.

This year, the State of Washington joined Oregon to become the second state to adopt an across-the-board cap on hospital payments under its state employee health plan. Like the Oregon law, the Washington law limits payments to 200 percent of Medicare rates for in-network hospitals and 185 percent for out-of-network hospitals. The bill mandates that all expected cost savings resulting from the payment caps be passed along to consumers via lower premiums.

The Washington law couples the hospital price cap with payment floors for certain services. The law requires that the state employee health plan pay for primary care and behavioral health services at no less than 150 percent of Medicare rates. In addition, not only does the law exempt critical access hospitals and other selected hospitals from the price cap, but it also goes as far as setting a reimbursement floor of 101 percent of Medicare allowable costs for services delivered at these hospitals.

When implemented for state employee health plans, reference-based hospital price caps could free up money in state budgets for their Medicaid programs. Such a policy would save the average state $150 million annually, while still maintaining healthy commercial hospital operating margins. (An interactive tool showing how much each state would save under different reference-price levels can be found here.) If directed to Medicaid, these savings could unlock significant federal matching funds for state Medicaid programs.

In addition to Washington, bills to establish reference-based hospital price caps in state employee health plans were also filed this session in Colorado (where the caps would also apply to small group plans), Nevada, and New Jersey. Several other states have begun to pursue forms of reference-based hospital price caps in their state employee health plans through administrative action, rather than legislation. These will all be states to watch as their legislatures reconvene for new legislative sessions in 2026.

**Price Caps In The Commercial Market**

Market failures have led states with both Democratic and Republican leaders to intervene more directly in commercial health care markets by implementing price caps that apply across the commercial sector. In 2025, Vermont and Indiana became the first two states to enact legislation to cap hospital prices across all commercial payers. They did so by capping the prices that hospitals can charge, rather than the amount that insurers can reimburse hospitals—thereby bypassing federal restrictions on states' ability to regulate self-insured plans. These two very different states enacted similar policies to address the same underlying problem of high and rising hospital prices.

Vermont's new law directs the Green Mountain Care Board (GMCB), an independent board responsible for regulating and evaluating the state's health care system, to establish upper limits on the amounts that hospitals can accept as payment for health care services, based on a percentage of Medicare rates. These limits must be established by hospital fiscal year 2027. The law also directs the GMCB to ensure that the savings are passed along to rate payers through lower insurance premiums and to report on this annually.

The reference-based price caps in the Vermont law serve as stepping stones toward establishing global hospital budgets, which the GMCB must set across all hospitals by hospital fiscal year 2030. Global hospital budgets set a cap on the total patient revenue that a given hospital can receive in a year. Notably, this policy has been in place in Maryland since 2014.

Like the Washington law, the Vermont law couples the price caps with price floors for certain services. The new law allows the GMCB to establish reference-based payment floors across all payers for services provided in nonhospital settings, such as primary care services.

Indiana's law differs from the Vermont law, both in terms of the hospitals it covers and the reference price for the cap. The new law requires nonprofit hospitals to bring their aggregate average inpatient and outpatient prices under statewide averages by June 2029. If a nonprofit hospital fails to meet this requirement, the hospital must forfeit its nonprofit status until it can lower prices below the average.

In addition to Vermont and Indiana, bills to establish reference-based hospital price caps that would apply to all patients were filed this session in Massachusetts, Montana, and Oklahoma. These bills have been drafted by both Democrats and Republicans, demonstrating the bipartisan support behind this policy.

Because of their inherent impact on hospital revenue, price controls in the commercial market should be implemented in a way that closely monitors their impact on hospitals' financial health. Vermont and Indiana's laws take steps to do just that. Vermont's law directs the GMCB to "identify factors that would necessitate terminating or modifying" price caps in hospitals, including reductions in care access or quality. The Indiana law includes a provision requiring nonprofit hospital systems to submit audited financial statements to the state annually, ensuring the state can monitor the impacts of the price caps.

**Conclusion**

As states are facing rapidly increasing health care costs, policy makers are increasingly turning toward hospital price controls as a solution. When implemented in state employee health plans, reference-based hospital price caps have the potential to save

states money that can be reallocated to crucial services, while also increasing the paychecks of public employees. When implemented across the commercial market, reference-based hospital price caps have the potential to right-size health care spending, while also saving consumers money. States can learn from the examples of Indiana, Vermont, and Washington as they consider policy solutions for their own health care markets.

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