HEALTH CARE AFFORDABILITY: STATES ARE LEADING THE MOVE TOWARD HOSPITAL PAYMENT AND SPENDING CONTROLS

Implications if Democrats Control the House - and Potentially the Senate - in 2027

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1. States Are Setting the Direction of Health Care Payment Reform

The most important development is occurring in the states, not Washington. A growing number of states have moved beyond transparency, antitrust enforcement and voluntary affordability initiatives and are now directly constraining hospital prices, hospital revenue or overall health care spending. The approaches vary, but they increasingly fall into three categories: Medicare-linked payment ceilings, enforceable annual cost-growth targets, and hospital global-budget or budget-review systems.

This movement is becoming politically durable because it is not confined to Democratic states. Indiana has adopted one of the most consequential Medicare-linked hospital price requirements in the country, while Montana has used Medicare reference pricing for its state employee plan. Democratic-led states including California, Delaware, Oregon, Vermont and Washington are using other versions of the same basic strategy: government is increasingly setting the boundaries within which hospital prices or spending may grow.

The economic pressure behind these reforms is substantial. KFF found that private-insurance hospital prices increased 30% from April 2019 through April 2026, compared with 21% for Medicare, and hospitals accounted for roughly 40% of the growth in national health spending from 2022 through 2024. The emerging policy question is therefore shifting from whether government should intervene in hospital pricing to how aggressively it should intervene and what benchmark it should use.

2. Twelve State Models That Could Become Federal Templates

States are effectively creating the menu of options that federal policymakers could draw from. The most consequential examples are summarized below.

State	Key Limit	What It Does / Why It Matters
Indiana	260% of Medicare	Since Sept. 2025, large nonprofit systems must offer direct-to-employer arrangements at or below 260% of full Medicare; noncompliance can trigger $10,000 per hospital per day. The first state review reported system rates of 171%-250% of Medicare.
Washington	200% / 185% of Medicare	Beginning Jan. 1, 2027, state and school employee plans generally cap in-network hospital payments at 200% of Medicare and out-of-network payments at 185%. State estimate: more than $290 million in savings through FY2030.
Oregon	200% of Medicare; 3.75% growth	The state employee plan has used a 200%-of-Medicare hospital cap since 2019. Separately, Oregon set a statewide health-spending growth target of 3.75% annually for 2026-2030.
Delaware	250% of Medicare; budget review	An interim ceiling limits specified hospital charges to 250% of Medicare during 2025-2026, subject to exemptions. Hospitals also submit annual financial and budget data, with stronger state oversight when benchmarks are missed.
California	3.5% -> 3.0%; lower for high-cost hospitals	Statewide per-capita spending growth is limited to 3.5% in 2026, 3.2% in 2027-28 and 3.0% in 2029. Seven high-cost hospitals face targets of 1.8%, 1.7% and 1.6%, respectively.
Vermont	Reference prices by FY2027	Act 68 requires maximum reference-based hospital prices as soon as practicable, no later than hospital FY2027, and moves toward broader global-budget methodologies thereafter.
Maryland	All-payer global budgets	Maryland continues the nation's most developed all-payer hospital rate and global-budget system and is transitioning under the federal AHEAD model while maintaining broad prospective hospital revenue controls.
Connecticut	2.8% annual growth	The statewide per-capita health care cost-growth benchmark is 2.8% each year from 2026 through 2030.
Rhode Island	Affordability standard / growth controls	Rhode Island links insurance rate review to hospital affordability standards. CAP cites the state model as evidence that constraining hospital price growth can reduce hospital prices and premiums.

State	Key Limit	What It Does / Why It Matters
Montana	220%-250% of Medicare	The state employee plan moved inpatient rates to roughly 220%-225% of Medicare and outpatient rates to 230%-250%. Independent analysis estimated $47.8 million in savings over SFY2017-2019.
New York	Proposed 150% of Medicare	The Fair Pricing Act would cap about 60 routine outpatient services at 150% of Medicare regardless of site. Supporters estimate $1.14 billion in annual savings, including about $213 million in patient out-of-pocket savings.
New Jersey	Statewide HART benchmark	The HART program sets statewide health-cost growth targets and tracks hospital/provider, insurance and pharmaceutical spending - infrastructure that could support stronger enforcement if targets are repeatedly missed.

3. The Federal Risk in 2027 Is That Washington Adopts the State Playbook

A Democratic House would make federal health-cost legislation substantially more likely to move onto the congressional agenda. Sabato's Crystal Ball continues to favor Democrats to win the House, while Republicans remain favored to retain the Senate even though Democrats have a plausible path if they win essentially all of the pivotal races. A Democratic House alone could hold hearings, conduct investigations, develop legislation and pass health affordability bills. Democratic control of both chambers would increase the ability to move a coordinated package, although enactment would still depend on Senate procedure and the White House.

The significance of the state trend is that Congress no longer has to design hospital cost controls from scratch. Lawmakers can point to enacted state precedents ranging from roughly 200%-260% of Medicare, annual spending-growth limits near 3%, and global-budget systems. Those models provide both policy language and political cover for federal action.

4. The Wyden Senate Finance RFI Is the Clearest Democratic Signal

The July 30, 2026 Senate Finance Committee Democratic request for information led by Ranking Member Ron Wyden deserves particular attention. It is not legislation and it does not endorse a national hospital payment cap. But it is a formal policy-development document intended to inform future policymaking and legislative drafting after more than 80 listening sessions involving nearly 250 patient advocates, consumer groups, researchers, hospitals, physicians and health plans.

Most important for hospitals, the RFI explicitly connects state experimentation to possible federal payment reform. Senate Democrats ask whether state rate-review approaches should inform stronger federal standards; seek lessons from state public-option programs; and request feedback on federal public-option payment methodologies that could include HHS negotiation, statutory payment boundaries or reference benchmarks, Medicare payment rates as a benchmark or starting point, and a CMS-established public-option fee schedule modeled on Traditional Medicare.

The RFI goes beyond a conventional ACA expansion agenda. It asks for proposals to give all Americans access to a Medicare-type coverage choice regardless of income or employment, and it separately invites updated analysis of a federal single-payer system and the Medicare for All Act. In practical terms, the Finance Committee document places Medicare-based provider payment, public-option rate setting, state affordability models and single payer on the same policy-development menu.

For hospitals, that is the key warning sign. Even if Congress never enacts a universal commercial hospital price cap, a federal public option could introduce Medicare-linked or government-set hospital payment rates into a much larger share of the commercial market. State policies provide the precedent; the Finance Committee RFI provides a congressional pathway for adapting them nationally.

5. Center for American Progress Supplies a Concrete Federal Hospital Price-Cap Blueprint

The Center for American Progress (CAP) proposal is important because it turns the broader Democratic affordability debate into a specific hospital payment policy. CAP is a progressive policy

organization, not the Democratic Party, but its April 2026 Patients' Bill of Rights report provides a detailed model that a future Congress could use or modify.

- **300% of Medicare cap in concentrated markets.** CAP proposes legislation preventing hospital prices in highly concentrated markets from exceeding three times Medicare rates. CAP argues that because commercial hospital prices average about 250% of Medicare, the policy would initially target the highest-price outliers rather than impose Medicare rates on all hospitals.
- **Direct application to self-insured employers.** The ceiling would also apply to hospital prices charged to self-funded employer plans, extending federal payment regulation directly into the large-employer market.
- **Price-growth limits for other high-priced hospitals.** Hospitals with prices above the statewide median would have annual price growth limited to inflation plus 1 percentage point.
- **Enforcement tied to tax status and financial penalties.** CAP proposes potential loss of tax-exempt status for nonprofit hospitals exceeding the caps and financial penalties for for-profit hospitals, with HHS enforcement.
- **Required consumer pass-through.** Health plans would be required to return savings to workers through lower deductibles. CAP estimates an average deductible reduction of $933 - roughly cutting the average deductible in half in concentrated markets - and a $1,308 reduction in average annual family employer premiums by 2032 from its hospital price-growth policy.

CAP also makes the state-to-federal connection explicit. Its hospital recommendations rely heavily on lessons from Indiana and Rhode Island. That is precisely why state policy developments matter: they are creating tested mechanisms that national policy organizations can translate into federal legislative proposals.

6. Other Federal Payment Pathways Remain Available

Site-neutral payment remains the most immediately actionable hospital savings mechanism because it is already scored and has bipartisan support. CBO estimates that broad site-neutral Medicare payment for services furnished in hospital outpatient departments could reduce federal outlays by $156.9 billion over 2025-2034. That makes site-neutrality a ready-made financing offset for broader health legislation.

Medicare for All remains the most sweeping option but is not the only meaningful hospital risk. The current House Medicare for All legislation would use negotiated global operating budgets for institutional providers rather than simply paying every hospital claim at ordinary Medicare fee-for-service rates. The more plausible near-term risk is incremental: Medicare-linked public-option rates, targeted commercial price ceilings, annual price-growth limits, and site-neutral payment can each materially affect hospital revenue without Congress first adopting a full single-payer system.

7. Implications for Hospitals Going Into 2027

The immediate policy front is the states; the emerging strategic risk is federalization. Hospital payment reform is already occurring through state law and state purchasing programs. The combination of those precedents, the Wyden Senate Finance RFI and CAP's 300%-of-Medicare proposal creates a much more developed pathway toward federal hospital price intervention than existed only a few years ago.

- **Medicare is becoming the common reference point.** Several states now use Medicare multiples to define acceptable commercial hospital prices, and Senate Finance Democrats are explicitly asking whether Medicare should serve as the benchmark or starting point for a federal public option.
- **State spending targets create a second model.** California, Connecticut, Oregon and Rhode Island demonstrate that government can constrain hospital and health-system revenue growth without setting every individual claim price.
- **A Democratic House could accelerate the debate even without full control of Washington.** Committee hearings, investigations and House-passed legislation could establish hospital price caps or public-option payment rules as mainstream federal policy proposals. If Democrats also capture the Senate, the legislative risk would rise further.

- **CAP gives policymakers a ready-made middle ground between the status quo and Medicare for All.** A 300%-of-Medicare ceiling targeted to concentrated markets, combined with inflation-plus-1 price growth limits, can be presented as an outlier-pricing and consumer-affordability policy rather than a wholesale conversion to Medicare rates.

Bottom line: Hospitals should treat state payment reforms as the leading indicator for the 2027 federal affordability debate. The most consequential question may no longer be whether Democrats pursue Medicare for All, but whether federal policymakers borrow state tools - Medicare reference pricing, spending-growth limits and global-budget concepts - and apply them to a broader share of the commercial market.

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