Washington State Health Care Authority

PEBB/SEBB access and affordability

SB 5083 and **HB 1123**

Frequently asked questions (FAQ)

1. Why do we need a price caps program?

The United States, with Washington as no exception, is facing a health care affordability problem. Insurance premiums are rising at an unsustainable rate, forcing families and employers to make difficult tradeoffs about whether to spend on health care or other priorities.

Spending on hospital services make up nearly half of total spending on health care, and studies show this spending has grown rapidly, primarily due to price increases.[1] The math is simple: Washington cannot make a dent without addressing hospital prices.

As we spend more and more on hospital services, there has been chronic underinvestment in primary care and behavioral health. Payments for primary care and behavioral health services are insufficient, which has led to provider shortages in these areas of care.

Unfortunately, letting market forces run their course is not going to solve these problems. With demand for services remaining high regardless of costs and a heavily consolidated market that lacks real competition, normal economic pressures have not been the answer. Legislative action is needed to align health care payment to focus on prevention, and to better achieve our system goals of affordable, accessible, high-quality care.

2. How would hospital price caps help address our affordability problems?

The Health Care Authority (HCA) is proposing to institute price caps to rebalance how the state's Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) health plans pay providers to lower the cost of hospital care and increase or maintain reimbursement for primary care and behavioral health services. HCA is proposing to achieve this with the following measures:

- Limiting payments for hospital inpatient and outpatient services to no more than 200 percent of Medicare reimbursement starting January 1, 2027, phased down to 190 percent of Medicare on January 1, 2029.
- Setting a higher payment limit for children's hospitals, at no more than 350 percent of Medicare in 2027, phasing down to 300 percent of Medicare in 2029, in recognition of the very specialized population they serve.
- Setting minimum payment levels for primary care and behavioral health services delivered in community settings at no less than 150 percent of Medicare rates, ensuring access to important services that can prevent complications and promote mental health.

Oregon implemented similar legislation for its PEBB/OEBB programs in 2019 leading to reduced health plan expenditures and lower out of pocket costs, outlined in further detail under question 8.

[1] Onpoint, "Washington State Commercial Trends in Cost, 2016-2019," December 2022.

3. How would hospital price caps affect access?

To maintain access and ensure that hospitals do not leave the PEBB and SEBB plan networks, the proposed legislation combines hospital price caps with a requirement for hospitals to participate and contract with PEBB and SEBB insurers that put forward a good faith offer on payment for hospital services. This protection is particularly important since Washington has seen a recent uptick in major hospital systems threatening to leave the PEBB and SEBB plan networks if the plans do not meet demands for price increases. These types of network changes can cause significant confusion for employees and disrupt routine care.

Recognizing that residents in rural Washington face unique challenges in accessing care, the legislation proposes special treatment for critical access and sole community hospitals that serve rural areas by ensuring they continue to be paid at no less than 101 percent of what it costs them to deliver services.

4. To whom would the price cap requirements apply?

The price cap requirements apply to all PEBB and SEBB insurers offering employee coverage. This includes both fully insured and self-insured plans under the purview of HCA. The requirements would not apply to health insurance provided through non-PEBB and SEBB employers, insurance purchased through the Health Benefit Exchange, Medicaid, or Medicare.

5. Why do we need a policy on how to pay hospitals in PEBB and SEBB? Won't insurers do a better job of negotiating lower prices?

Many hospitals in Washington have significant market domination within a region, which gives them considerable leverage. In areas where there isn't much competition, hospitals can demand higher prices from commercial insurers in exchange for staying in the insurer's network. As a result, prices paid for the same services can vary significantly across hospitals, regardless of the actual cost of delivering the services or quality of care provided. For example, for the PEBB and SEBB self-insured plans, hospitals are paid a range of between 147 percent to 336.2 percent of Medicare, with no clear reasons for such widespread price variation.

Rather than relying on negotiations within a distorted market, paying hospitals based on Medicare rates provides a transparent, more equitable approach to determining hospital reimbursement rates for PEBB and SEBB plans. This policy — known as "reference pricing" — can help counter the wide variation in prices for hospital services that exists across Washington and would ensure hospitals are paid sufficiently while rebalancing spending towards critical primary care and behavioral health services.

6. Why are Medicare rates used for the payment benchmark?

Using Medicare as the benchmark for determining hospital payments can better align the price of receiving care with the costs of providing it, while helping to ensure that hospitals don't pocket excess profits. Medicare payment levels are meant to cover hospitals' costs and ensure that beneficiaries have access to high-quality care, while encouraging efficient use of resources. Medicare rates include many appropriate adjustments to account for factors such as regional differences in wages and other input costs, inflation, the cost of teaching programs, the share of low-income patients served by a hospital, and the level of uncompensated care.

In addition, Medicare rates are assessed and updated annually to ensure that payment levels are adequate for hospitals. This includes examining beneficiaries' access to care, the quality of care, hospitals' access to capital,

and how Medicare payments compare with hospitals' costs, particularly for hospitals deemed to be relatively efficient based on cost and quality performance.[2]

7. Don't we need to maintain the higher commercial payment rates to compensate for low reimbursement from Medicare and Medicaid?

Evidence does not support industry assertions that higher commercial payments are needed to compensate for underpayment in Medicaid and Medicare.[3, 4, 5] Extensive research shows that hospitals largely raise commercial prices to maximize revenue, rather than to recoup losses due to lower Medicare and Medicaid payment levels.[6] In addition, evidence shows that when hospitals are faced with financial pressures that limit their ability to raise their rates, hospitals manage their operating costs more efficiently, debunking the assertion that hospitals have little control over their costs.[7]

8. How would a price caps program help reduce health care costs for our state and our employees?

High hospital prices are a significant driver of rising premiums.[8] By reducing the prices paid for hospital services, Washington can reduce the growth in cost of providing insurance through PEBB and SEBB. This means cost-containment — in terms of lower premiums — for the state and its employees.

Lower hospital prices also lead to reduced cost-sharing obligations for members who use hospital services. Cost-sharing for outpatient services is based on a percentage of the allowed amount for the service. Therefore, lowering the amounts that hospitals can charge for outpatient services to no more than 200 percent of Medicare prices would lower members' cost-sharing obligations.

States that implemented similar policies showed meaningful savings. For example, Oregon limits hospital payments to 200 percent of Medicare for in-network services and to 185 percent of Medicare rates for out-of-

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[2] MedPAC Report to Congress: Medicare Payment Policy (March 2024): https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf (pp. 42-45, 72-75).

[3] Blavin F, Kane N, Berenson R, Blanchfield B, Zuckerman S. Association of Commercial-to-Medicare Relative Prices With Health System Financial Performance. *JAMA Health Forum*. February 2023, 4(2). (Study found that for large health systems, higher commercial-to-Medicare relative prices and a lower Medicaid payer share were associated with higher profits and more days with cash on hand. These findings show that relatively higher commercial prices were used to increase profits and liquidity, rather than primarily to offset losses from public payers.)

[4] Congressional Budget Office. The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. January 2022, 26-28. (Data analysis and literature review found no evidence that the share of providers' patients covered by Medicare or Medicaid played any part in commercial market hospital and physician services price variation in most settings.)

[5] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy, Chapter 15: Congressional request on health care provider consolidation. March 2020, 468-469, 497-499 (Appendix 15-A). (Examined literature testing the cost-shift theory and found that when Medicare or Medicaid revenues increase, hospitals with more market power still aim to negotiate larger, rather than smaller, rate increases from commercial insurers.)

[6] Medicare Payment Advisory Commission Report to Congress. March 2023 (pages 47, 78, 101 [endnote 26]).

[7] Medicare Payment Advisory Commission Report to Congress. March 2023 (pages 47, 78, 101 [endnote 26]).

[8] Kanimian S, Ho V., "Why Does the Cost of Employer-sponsored Coverage Keep Rising?" Health Aff Sch. 2024 Jun 4;2(6):qxae078. doi: 10.1093/haschl/qxae078. PMID: 38915812; PMCID: PMC11195578.

network services in their state and school-based employee plans. In the first 27 months of implementation, this policy yielded $107.5 million in savings for the state, amounting to 4 percent of plan spending.[9] In addition, they found a 9.5 percent reduction in out-of-pocket spending per outpatient procedure for individuals enrolled in high cost-sharing plans.[10]

Cost-sharing for an intensive emergency department visit for a member enrolled in the Classic Uniform Medical Plan for individual coverage

	Allowed amounts	Cost-sharing after $250 deductible
Medicare fees	$613	NA
Current plan fees	$1,562	$272
Fees capped at 200% of Medicare	$1,226	$221

Out-of-pocket cost savings for member = $51 or 23%

9. How can we make sure that price caps would work as intended, and wouldn't negatively impact cost and access to care for our employees?

HCA would work with the Office of the Insurance Commissioner to monitor the impacts on access to care, premium levels, and how much the state spends on medical care for public and school-based employees.

HCA would also oversee compliance by annually reviewing payment data from the PEBB and SEBB insurers to ensure that hospital, primary care, and behavioral health payment rates are projected to meet the program's payment limits and floors. HCA could then review how much hospitals and providers are actually paid to check if those rates matched the projections.

10. How would price caps impact the state budget?

A recent analysis of Oregon's hospital payment cap legislation found that "[h]ospital payment caps can be successful in targeting outlier hospital payments and generating savings for the state."[11] Limiting spending on hospital services in Washington has been modelled to account for over $400 million in cost-containment between Fiscal Year (FY) 2025 and FY 2029, decreasing out-of-pocket costs and affording the state the opportunity to invest in other critical priorities. Cost modelling completed by HCA shows that for FY2027, the legislation could drive a reduction in operating expenditures of about $75 million, increasing to over $241 million per year by FY 2030, inclusive of increased investments in primary care and behavioral health services.

The projected cost-containment may not translate to dollar-for-dollar premium reductions, given other variables such as population, utilization and regulatory changes may impact prices over time. However, budget projections assume this legislation could drive substantive decreases in state expenditures and correlating decreases in out-of-pocket costs for state and school employees.

[9] Murray, R.C., Brown, Z.Y., Miller, S., Norton, E.C., Ryan, A.M., "Hospital Facility Prices Declined As A Result of Oregon's Hospital Payment Cap," Health Affairs, March 2024.
[10] Murray, R.C., Norton, E.C., Ryan, A.M., Oregon's Hospital Payment Cap and Enrollee Out-of-Pocket Spending and Service Use," JAMA Health Forum, August 2024.
[11] Murray, R.C., Brown, Z.Y., Miller, S., Norton, E.C., Ryan, A.M., "Hospital Facility Prices Declined As A Result of Oregon's Hospital Payment Cap," Health Affairs, March 2024.

11. Won't this policy result in hospitals increasing prices for other services or for non-PEBB/SEBB commercial insurance plans?

Not necessarily. When Oregon implemented a similar program, they did not see prices for other insurance plans or services go up.[12] There is no evidence to suggest that Washington's experience will be different.

Analyses suggest that there is room for hospitals to lower their prices and still cover their expenses and generate a profit. For example, the National Academy for State Health Policy (NASHP) hospital cost tool helps illustrate what the projected "commercial breakeven" point is for hospitals — the level of commercial reimbursement, relative to Medicare, needed to allow the hospital to cover maximum expenses, with no profit, for inpatient and outpatient services when factoring in operating costs, shortfall from public payers, and charity care. The commercial breakeven for Washington using 2022 data was 153 percent of Medicare. NASHP projects it to lower to around 136 percent of Medicare with increased payments from the state's Medicaid hospital safety net program now effective (effectively reducing "shortfall" from public payers). However, internal analyses show that self-insured PEBB and SEBB plans pay acute care hospitals on average between 147 percent to 336 percent of Medicare, while children's hospitals are paid up to 425 percent of Medicare.

12. Won't a cap on hospital payments put hospitals in financial difficulty and increase the likelihood of mergers and/or private equity investment?

Not likely. Washington's market is already highly consolidated and the high prices resulting from this consolidation are what the policy would try to address.

As explained in question 6, Medicare is a reasonable benchmark meant to cover hospitals' costs while ensuring access to high-quality care. A benchmark level set at approximately twice the amount of what Medicare pays should be more than sufficient to cover hospitals' expenses, protect them from financial hardship, and even allow them to maintain a profit. This benchmark would provide a buffer of 47–67 percent above what expert analyses have found that Washington hospitals would need to cover their maximum expenses, as explained in question 11. In addition, the policy could provide further protections for critical access and sole community hospitals that service rural areas, as these hospitals are subject to fluctuations in revenue that can put them at greater financial risk.

13. Isn't the state already doing other things to address health care affordability? Why do we need another affordability policy on top of other initiatives we are already pursuing?

Tackling our health care affordability problem requires a multitude of actions. This policy align with other efforts the state is already undertaking to make sure residents can access high-quality, affordable care. This program would also build on successful payment policies implemented under Cascade Care, extending the benefits of lower hospital prices that Cascade Care members have to the state's public employees.

[12] Murray, R.C., Brown, Z.Y., Miller, S., Norton, E.C., Ryan, A.M., "Hospital Facility Prices Declined As A Result of Oregon's Hospital Payment Cap," Health Affairs, March 2024.

In addition, a requirement to pay for primary care and behavioral health services at no less than 150 percent of Medicare rates would sustain investment in primary care and boost payment to behavioral health providers, helping plans invest in preventive care and address problems at an early stage. Investing in primary care can help reduce complications and the need for more costly treatments down the road.

Reference pricing is also consistent with the goals of House Bill 2457, which the legislature passed in 2020 to establish the **Health Care Cost Transparency Board**. Pegging PEBB and SEBB hospital payments to Medicare rates would bring greater transparency into how the state pays for services and would bring down the cost of hospital services to help meet the state's goals to slow the growth in health care costs to no more than 3.0 percent in 2025.