CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

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Impact of Hospital Price Regulations on Health Care Spending

Lessons from Price Regulations in Other States

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Testimony of Roslyn C. Murray submitted to the Health and Human Services Committee of the Maine State Legislature on LD 2196 and the impact of hospital price regulations on health care spending on March 5, 2026.

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Before the Health and Human Services Committee
Maine State Legislature

March 5, 2026

[1] The opinions and conclusions expressed in this testimony are the author's alone and do not reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.
[2] The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairs Ingwersen and Meyer, and members of the committee, thank you for the opportunity to provide written testimony on the impact of hospital price regulations. My name is Roslyn Murray, and I am an assistant professor of Health Policy at the Brown University School of Public Health and a research faculty member at the Center for Advancing Health Policy through Research, where I focus on evaluating policies and programs designed to improve health care affordability in the United States, including policies such as those contemplated in LD 2196. The information I share today draws on various studies my colleagues and I have conducted evaluating hospital payment policies and my expertise in hospital payment reform.

Hospital Prices Contribute to Growing Affordability Concerns in the U.S.

Hospital prices are a main driver of rising health care spending in the United States.[3, 4, 5] Spending on hospital care amounted to $1.6 trillion in 2024.[6] A substantial body of research demonstrates that high prices are largely driven by provider market power—often amplified through mergers and acquisitions—rather than through higher quality or higher costs of care.[7, 8, 9, 10] Over the past few decades, studies have shown that hospital prices in the commercial market have increasingly diverged from Medicare payments, which are generally considered a break-even level for efficient hospitals.[11, 12, 13]

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[4] Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: Why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood), 2019; 38(1).

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[11] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2024 Mar. Chapter 3, Hospital inpatient and outpatient services; [cited 2025 Jan 28]. Available from: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch3_MedPAC_Report_To_Congress_SEC-1.pdf

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[13] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2020 Mar. Chapter 3, Hospital inpatient and outpatient services; [cited 2024 Mar 5]. Available from: https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/

Nationally, average inpatient facility prices rose from 110% of Medicare payments in the late 1990s to 254% of Medicare payments in 2022.[14] On average, inpatient facility prices in Maine were 228% of Medicare payments in 2022, while outpatient facility prices were 300% of Medicare payments.[15]

The burden of high and rising health care spending primarily falls on U.S. workers and their families through increasing premiums and out-of-pocket spending, including high-deductible health plans.[16] The average premium cost for a family insurance plan is $26,993, and in many exchange plans, the average deductible is almost $3,000.[17, 18] Rising health care spending also slows wage growth and contributes to job losses, as workers become more expensive to employ.[19]

State Efforts to Control Hospital Prices and Price Growth Have Saved Employers, Purchasers, and their Members Millions

As health care spending continues to increase, several states have pursued policy interventions to improve affordability by directly regulating or capping hospital prices. Rhode Island was among the first states to adopt this approach, implementing Affordability Standards in 2010 that, among other things, limit annual growth in hospital facility fees. The Affordability Standards cap annual increases in hospital prices at inflation plus one percentage point. Even though the price growth limits apply only to fully-insured plans, the evidence suggests that the policy also led to price reductions across insurance companies' self-insured business. In joint work with my colleagues at Brown, we found that the Standards were associated with a 9.1% average reduction in hospital facility fees and a 6.5% average reduction in fully-insured premiums over an eleven-year period (**Figure 1**). We further estimate that these price and premium reductions translated into approximately $87.7 million in annual savings in the fully-insured market, totaling $1.14 billion in cumulative savings from 2010 through 2022.[20] However, our research found that these constraints also reduced hospital revenues, potentially contributing to lower operating

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[20] Ryan AM, Whaley CM, Fuse Brown EC, Radhakrishnan N, Murray RC. Rhode Island's affordability standards led to hospital price reductions and lower insurance premiums. Health Aff (Millwood). 2025;44(5):597-605.

margins for Rhode Island hospitals relative to hospitals in surrounding New England states, alongside other factors such as cuts to Medicaid payments.

Figure 1. Difference in commercial health insurance premiums between Rhode Island and comparison states, by insurance market segment, 2006-22

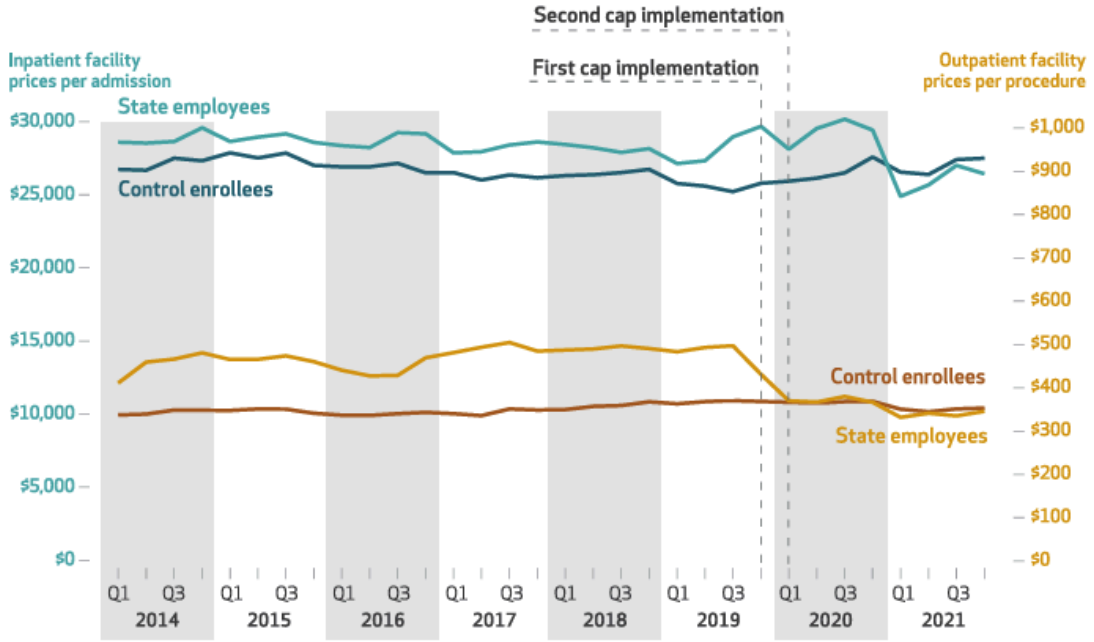
Other states have pursued hospital price regulation by setting service-level price caps. Oregon was the first state to do this through legislation. Since 2019, the state has capped hospital prices paid by the state employee health plan at 200% of Medicare payments for in-network services and 185% for out-of-network services.[21] Patients cannot be charged more than their in-network cost-sharing amounts. The legislation applies to 24 of Oregon's large, urban hospitals and exempts critical access hospitals and other small and rural hospitals in the state. In our evaluation of Oregon's policy, my colleagues and I found that outpatient facility prices paid by the state employee plan decreased by 25%, while inpatient facility prices dropped by 3%, resulting in $107.5 million in savings for the state over the first two years and three months—about 4% of total plan spending (**Figure 2**).[22] Enrollees in higher cost-sharing plans

[21] Oregon State Legislature. 79th Oregon Legislative Assembly—2017 Regular Session, SB 1067 enrolled, Relating to government cost containment; and declaring an emergency, Chapter 746 [Internet]. Salem (OR): The Legislature; [cited 2024 Feb 12]. Available from: https://olis.oregonlegislature.gov/liz/2017R1/Measures/Overview/SB1067

[22] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024; 43(3).

experienced a 9.5% reduction in out-of-pocket spending, with only slight increases in service use, which provides early evidence that state employee members are not experiencing access to care challenges.[23]

Figure 2. Average hospital facility prices per admission (inpatient) or procedure (outpatient) for Oregon state employee plan enrollees versus control enrollees, by quarter, 2014-21



To date, all 24 hospitals have remained in the state employee plan's network, and none have closed. In line with a broader body of research, we found no evidence of "cost-shifting" to commercial plans during the first two years and three months of the cap; facility prices for non-state employee commercial enrollees at the 24 hospitals were not statistically different from prices at Oregon's non-exposed hospitals from October 2019 through December 2021.[24, 25] Further, my more recent analysis has found that Oregon's payment cap had a minimal impact on hospital finances (about a 1% reduction in hospital net patient revenue, on average), and thus, had no negative impact on hospital operations, staffing, or patient experience of care.[26] These findings suggest that Oregon's hospitals have been able to improve health care affordability for state employees and their dependents and still cover their costs and keep the doors open.

[23] Murray RC, Norton EC, Ryan AM. Oregon's hospital payment cap and enrollee out-of-pocket spending and service use. JAMA Health Forum. 2024;5(8):e242614. doi:10.1001/jamahealthforum.2024.2614
[24] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital facility prices declined as a result of Oregon's hospital payment cap. Health Aff (Millwood). 2024; 43(3).
[25] Frakt AB. How much do hospitals cost shift? A review of the evidence. Milbank Quarterly. 2011; 89(1):90-130.
[26] Murray RC, Ryan AM, Whaley CM. Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented. Health Aff (Millwood). 2025;44(12):1482-9.

Building off the experience of Oregon, other states have taken action to cap hospital prices. In 2025, the State of Washington joined Oregon to become the second state to adopt a service-level cap on hospital payments through legislation under its state employee health plan.[27] Like the Oregon law, the Washington law limits prices to 200% of Medicare payments for in-network services and 185% for out-of-network services. Also in 2025, Vermont and Indiana became the first two states to enact legislation to cap hospital prices across all commercial payers. Vermont's new law directs the Green Mountain Care Board, an independent board responsible for regulating and evaluating the state's health care system, to establish by 2027 upper limits on the amounts that hospitals can accept as payment for health care services, based on a percentage of Medicare rates.[28] Indiana's law requires nonprofit hospitals to bring their aggregate average inpatient and outpatient prices under statewide averages by June 2029. Any nonprofit hospital that fails to meet this requirement will have to forfeit its nonprofit status until it can lower prices below the average.[29]

Maine's Proposed Bill Has the Potential to Improve Health Care Affordability

Maine's proposed legislation aims to improve health care affordability and lower costs for patients. The bill would establish a service-level cap at 200% of Medicare payments—the same cap level established in Oregon and Washington—with exemptions for critical access hospitals and other financially distressed hospitals. Like the Indiana and Vermont laws, this bill would apply to the broader commercial market, with price growth caps that target all commercial hospital prices The bill would also establish service-level price caps that apply to fully-insured plans, as well as self-insured plans that opt in. Further, the legislation includes restrictions on prior authorization and utilization review and funnels savings from the caps to institute payment floors for primary care and behavioral health services.

Based on publicly available data from the RAND Hospital Price Transparency Study and the National Academy for State Health Policy Hospital Cost Tool on hospital prices and operating costs, I estimate that the service-level caps could generate $1 billion in annual savings to Maine patients and purchasers if applied to all services provided by short-term general acute care hospitals in Maine. In 2022, these hospitals generated $6.5 billion in net patient revenue, with aggregate operating margins of 28.4%.[30]

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[27] Senate Bill 5083: Ensuring access to primary care, behavioral health, and affordable hospital services [Internet]. Wash. 69th Leg., Reg. Sess. (2025). Available from: https://app.leg.wa.gov/billsummary?BillNumber=5083&Year=2025&Chamber=Senate
[28] S.126: An act relating to health care payment and delivery system reform [Internet]. 69th Gen. Assemb., Reg. Sess. (VT 2025-2026). Signed by Governor June 12, 2025 (Act 68). Available from: https://legislature.vermont.gov/bill/status/2026/S.126
[29] House Bill 1004: health care matters [Internet]. 124th Gen. Assemb., Reg. Sess. (IN 2025). Available from: https://iga.in.gov/legislative/2025/bills/house/1004/details
[30] National Academy for State Health Policy. NASHP Hospital Cost Tool [Internet]. NASHP; 2025 Feb 7 [cited 2025 Feb 21]. Available from: https://tool.nashp.org/

The anticipated revenue reduction would represent about 15% of these hospitals' net patient revenue and would result in a 13.1 percentage point reduction in their aggregate operating margins to 15.3%. Unlike other sources, NASHP's definition of operating margins focuses strictly on revenue and expenses related to hospital patient care and hospital operations, providing a clearer view of hospitals' financial viability based solely on their core mission—delivering patient care.

Conclusion

Hospital prices remain a significant contributor to rising health care spending, with implications for purchasers, patients, and state budgets. My research demonstrates that Rhode Island's hospital price growth caps, implemented as part of the state's Affordability Standards, and Oregon's hospital payment caps were associated with reductions in hospital prices and spending. The existing research suggests that thoughtfully crafted price regulations can effectively lower health care costs without significantly disrupting hospital operations or patient access. Maine's proposed legislation reflects a similar policy approach and may have the potential to achieve comparable affordability objectives.