The Decline of State-Based Hospital Rate Setting: Findings and Implications

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I. EXECUTIVE SUMMARY

This paper summarizes the results of a conference in Albany, New York in November, 1994 that brought together representatives from the four current and former "all payer" rate setting states of Maryland, Massachusetts, New Jersey and New York.

State based prospective hospital rate setting has declined from its former position as "the center of the policy paradigm for controlling health care costs" that it held in the 1970s. In 1980, about 30 states had some form of payer or budget regulation of hospitals; today, only six maintain any form of mandatory rate setting or budget controls: Florida, Maine, Maryland, New York, Rhode Island, West Virginia; Arizona and Vermont maintain voluntary systems.

Massachusetts and New Jersey -- along with others -- have deregulated their systems in recent years; New York is now facing circumstances similar in many respects to those that led to deregulation in the former two states. Of the four, only Maryland, helped by a Medicare waiver that brings more federal dollars to the state than the Prospective Payment System, seems determined for now to stay on the regulatory route.

Rate setting has been determined a success in holding down the rate of growth in per admission and per diem costs relative to non-rate setting states. While some evidence suggests success in holding down per capita hospital and health care cost growth, the evidence supporting this position is less clear.

Managed care represents the major challenge and the successor paradigm to prospective rate setting. While rate setting systems are designed to provide equity and parity among all payers, HMOs' approach is to contract aggressively with hospitals for the best possible deal. As HMOs have grown in rate setting states such as Massachusetts and New York, their efforts have destabilized the consensual regulatory structures in those states; only Maryland has been able to maintain stability in its rate setting system in the context of rapid HMO growth.

Coverage of hospitals' bad debt and charity care costs has been one of the most characteristic features of rate setting. But the size of the cost shift in New Jersey led to legal challenges under the federal ERISA law that toppled that state's system. Similar litigation threatens the rate setting system in New York which finances bad debt and charity care as well as several other health initiatives. Insurance reform efforts vary greatly among all states and also among rate setting states. There is nothing about the rate setting model that encourages or inhibits a state from undertaking such reforms.

Rate setting states have been able to accumulate abundant information and data on their systems that assists policy makers
in their decisions. The information challenge in deregulated states is to assist consumers, payers, and providers to survive in a competitive market. Policymakers in Massachusetts and New Jersey are attempting to develop that role.

Recently, rapid growth of capitation models has led some to seek lessons from the rate setting experience. This leads to the question of whether managed care is a departure or evolution from prior and existing rate setting structures. Experiments in Maryland that combine rate regulation and capitation may hold important lessons for both models.
II. INTRODUCTION

At times, major policy change occurs dramatically and
suddenly before the astonished gaze of knowledgeable observers
who never could have predicted such seismic shifts in a policy
landscape. At other times, major change occurs in a more incren-
mental and subtle manner, eluding the notice of most until --
after the fact -- attention is called to the fact that the ground
beneath us has shifted.

This paper, the result of a policy conference in Albany, New
York on November 22, 1994, concerns the latter form of change.
It calls attention to a noticeable decline in the use by state
governments of prospective hospital rate setting as a tool to
control inpatient hospital costs. In so doing, we review the
history and status of these programs in the four states that most
prominently used this form of regulation. We examine the lessons
learned from this experience relating to cost control, impact on
payers, managed care, access for the uninsured, insurance reform,
and information systems. Finally, we attempt to elicit lessons
from this experience for future state health policy initiatives.

1. Federal Support and Encouragement

Interest in state-based hospital rate setting was high
throughout much of the 1970s and 1980s not only in state capitals
but also in Washington, DC as policymakers sought means to
control rapidly rising health costs in general and inpatient
hospital costs in particular. The impact of Medicare and
Medicaid, together with growing employer health costs, created a
reaction to traditional cost-based reimbursement mechanisms that
had been built into these public and private programs.

In 1972 amendments to the Social Security Act, Congress gave
states explicit authority for the first time to establish
prospective rate setting programs in their jurisdictions to
experiment with new ways to control rising hospital costs.1 A
number of states, particularly Maryland and New Jersey, were
encouraged and, at times, prodded by federal officials to move
forward with their experiments.

President Jimmy Carter’s unsuccessful hospital cost contain-
ment proposal in 1979 was an attempt to impose this form of
prospective rate setting on all acute care hospitals across the
nation. Despite the hostility of President Ronald Reagan’s
Administration to rate setting, Congress passed further amend-
ments in 1983 2 directing the Health Care Financing Administra-
tion to grant Medicare waivers to states seeking to establish

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1 PL 92-603, Social Security Amendments of 1972.
all-payer prospective rate setting systems.

In addition to encouraging states to move in the direction of rate setting, the federal government also moved in that same direction for its major health related program, Medicare. In creating the Prospective Payment System in 1983, Congress and the Administration drew on the earlier experiences of New Jersey with diagnosis related groups (DRGs) to establish prospective per-case units of payment. With federal support, New Jersey had pioneered in the use of DRGs to pay hospitals a set rate for each case based on a patient's diagnosis. The establishment of the resource based relative value scale (RBRVS) in 1991 was a further federal effort to create a DRG parallel by setting rates prospectively for physician services. More recently, H.C.F.A. is working to set DRG rates of payment for outpatient hospital services.

2. State Initiatives

The first examples of states engaging in prospective rate setting can be found in Southwest Ohio in 1948 and in Indiana in 1959, though New York established the first mandatory system in 1970 (Sloan 1983b). The systems began as a response to dissatisfaction with cost-based reimbursement, then the principal form of payment in health care finance. By establishing a rate of payment in advance of the period over which the rate would apply, prospective rate setting created efficiency incentives that were considered to be absent under the cost-based reimbursement model.

With active federal encouragement, by 1980 more than 30 states moved to adopt forms of prospective rate setting or hospital budget control which was termed "the center of the policy paradigm for controlling health care costs during the 1970s" (Anderson 1991). Key interest groups were active and influential in this process. Throughout the 1970s, the American Hospital Association (AHA) actively promoted state-based rate setting as their preferred policy option to head off threats of increasing federal interference in their operations. But in July, 1980, "less than one year after Congress rejected President Carter's Hospital Cost Containment Act of 1979, the AHA House of Delegates voted formally to abandon its promotion of state rate setting" (Crozier 1982).

By contrast, the Health Insurance Association of America (HIAA) intensified its support of state-based rate setting into the 1980s in order to address cost shifting from Blue Cross plans and public payers, and won legislative battles in some key states. Organized labor maintained a strong position in support of rate setting, as did a number of private business coalitions in selected geographic areas across the nation (Crozier 1982).

A variety of factors have been identified as predictors of a
state's willingness to adopt rate setting; these include: high personal per capita income, high population density, high physician to population ratio, and high market shares for Blue Cross and Medicaid (Sloan 1983a); also, high costs per admission and per capita (Morrissey and others 1984); also, politically liberal states with budget deficits and large Medicaid hospital expenses (Cone and Dranove 1986).

3. Structure and Performance

While more than 30 states have been identified that enacted some form of prospective rate setting by 1980, the systems showed wide variation in both structure and operation. AHA devised a fourfold classification system in 1980: 1. mandatory-regulatory; 2. mandatory-advisory; 3. voluntary-regulatory; and 4. voluntary-advisory. A consistent finding in empirical literature evaluating rate setting performance is that only number one -- mandatory-regulatory systems -- demonstrates significant differences in performance from non-rate setting states (Ashby 1984).

Six "mandatory-regulatory" states have been the subject of most empirical analysis of rate setting: Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington. (Of these six, only Maryland and New York maintain their systems today.) The criteria that distinguished the models in these states are: 1. the system is (was) run by a state agency; 2. compliance by hospitals is (was) mandatory; 3. a majority of non-Medicare hospital expenses are (were) subject to regulation; and 4. the system has been (was) in effect since 1976 (Schramm and others 1986).3

A. All Payer Rate Setting: Of the six, four obtained federal waivers to permit Medicare and Medicaid to participate in "all-payer" reimbursement systems (Maryland, Massachusetts, New Jersey, and New York). Currently, only Maryland retains such a waiver. This distinction has drawn attention of analysts to the performance of rate setting in these four states more than others. It also helps to explain the rationale behind the select invitation list to the November 22, 1994 Albany conference. One study that compared the performance of all-payer to partial-payer prospective systems did not produce findings of significantly different rates of growth (Zuckerman 1987).

3Maine and West Virginia established mandatory rate setting programs in 1983 and 1984. These programs have not been subject to the same empirical analysis as the other six because of their later establishment and the consistent finding that state rate setting programs require several years of operation before they are found to have any measurable effect on costs (Coelen and Sullivan 1981).
B. Cost Containment: A large body of empirical literature has examined the performance of state rate setting over the past 15 years. The largest, initiated by H.C.F.A., concluded in its 1986 final report that "mandatory programs saved $36 billion from 1969 to 1982 and reduced costs per discharge in states with mandatory programs 12-26 percent" (Coelen and others 1986). A 1988 study, examining the performance of the four all-payer states compared with California and the rest of the nation found that between 1982 and 1986, the rate setting programs "reduced inflation rates by 16.3% in Massachusetts, 15.4% in Maryland, and 6.3% in New York, compared with the control hospitals in 43 states" (Robinson and Luft 1988).

Critics of these results suggested that per admission or per discharge measures were inadequate because they failed to detect shifts to other forms of spending; they suggested that the impact of state rate setting on per capita hospital costs and on total health spending were more appropriate measures. But studies in 1983 and 1986 found a pattern of lower per capita hospital costs in rate setting states (Morrisey and others 1983) (Schramm and others 1986). And while one 1987 study concluded that "the impact of rate regulation on total medical care expenditures reveals a mixed performance" (Finkler 1987), other studies have found reductions in total health spending of as much as 4.3 percent per annum (Lanning and others 1991).

C. Other Findings: Benefits found in rate setting programs have included improvements in access for the uninsured through the use of uncompensated care pools that shared these costs through a surcharge mechanism paid by users of hospital services (Hsiao and others 1986) (Thorpe 1987). These surcharges used to finance pools have also been the source of legal challenges to rate setting laws based on claims that they violate the 1974 federal ERISA law that prohibits state regulation of self-insured employer health plans. Rate setting has been found to reduce cost shifting among both public and private payers (Rosko 1989), as well as to improve efficiency in producing hospital care (Hadley and Swartz 1989).

Negative effects of state rate setting have been found to include longer lengths of hospital stays and higher rates of admissions (Ashby 1984), as well as potential negative effects on the quality of patient care (Gaumer and others 1989).

One oft-predicted effect of rate setting -- that it would slow the development of alternative health systems such as health maintenance organizations and managed care -- has not occurred. Indeed, one 1983 study observed that rate setting was positively related to the presence of pre-paid group practice and independent practice associations (IPAs) (Over and others 1983). In his 1991 review of state all-payer rate setting, Anderson noted that all mandatory rate setting states except New Jersey had penetra-
tion rates above the national average (Anderson 1991).

This finding does not suggest that rate setting is responsible for managed care growth, only that the factors leading a state to adopt rate setting (ie: high per capita health costs) also create a conducive environment for HMO development, a fact noted by McLaughlin: "HMOs should flourish in areas where hospital expenses are higher (McLaughlin 1987).

4. Rate Setting’s Decline

In spite of the favorable empirical findings relative to state rate setting’s performance, there can be little doubt that this tool has been laid aside by many states. A recent mail survey of states found only six that still maintain any form of mandatory revenue or budget controls for payers other than Medicaid.4 5

Of the six prominent mandatory-regulatory states, four have deregulated since 1989: Washington in 1989, Massachusetts in 1991, New Jersey in 1992, and Connecticut in 1994. Current circumstances in New York bear a strong resemblance to those in Massachusetts in 1991, including the election of market oriented Republican governor, the looming sunset of the current rate setting statute, and a spending crisis in the Medicaid program. These parallels lead to speculation that New York’s system may be the next to be deregulated or substantially altered.

5. The Albany Conference

The impending sunset of the fifth version of New York’s Prospective Hospital Reimbursement Methodology (NYPRHM V) at the end of 1995 led state officials to seek input from officials representing the other three current and former all-payer states. The Governor’s Health Care Advisory Board organized the "Meeting of Rate Setting States" on Tuesday, November 22, 1994 at the Rockefeller Institute in Albany.

Two representative attended from New Jersey, two from Maryland, and three from Massachusetts. About twenty New York officials, public and private, were in attendance. While the meeting was planned and organized well before the November 8 election in which State Senator George Pataki defeated incumbent

4 Survey conducted by the author, December, 1994. Information available by request.
5 A 1993 report found that 21 states maintain prospective payment models for Medicaid alone (see Hegner, Richard; "State Medicaid Inpatient Hospital Reimbursement Through Prospective Payment Systems"; Intergovernmental Health Policy Project, George Washington University; November, 1993). The systems described in the four states discussed in this report differ in their efforts to control hospital rate increases for private as well as public payers.
Governor Mario Cuomo, the implications of that transfer were understood in the November 22 session. While previously, policymakers were expecting "tinkering" and modest changes to NYPHRM V, it was clear that the rationale for the entire system would be held to increased scrutiny by the new Administration. Also, pending federal court cases challenging aspects of the New York rate setting system added more uncertainty to the prospects for the next reimbursement law.

The paths of Maryland on one hand, and Massachusetts and New Jersey on the other, presented a stark set of choices for the New York audience. In this report, section III (state updates) and section IV (issue discussions) represent the substance of the discussions on November 22 as well as the conference materials prepared in advance by officials from the participating states.

II. STATE UPDATES

1. MARYLAND

Unique -- and increasingly so -- is the word that most comes to mind in characterizing Maryland's history with prospective rate setting. Of 50 state hospital associations, only Maryland's is governed by the chairpersons of hospital boards of trustees (the other 49 are more typically governed by hospital chief executive officers).

The belief that board chairs will take a broader perspective on health concerns than bottom-line oriented CEOs seems to have taken hold in Maryland. The original rate setting legislation was approved in 1971 at the urging of the Maryland Hospital Association. The law was drafted by hospital trustees who were lawyers, and ushered through the State Senate by trustees who served in that body. Unlike other rate setting laws, Maryland's contained only broad systemic goals, leaving the development of rate setting methodology to the seven members of the newly created Health Services Cost Review Commission. Indeed, the HSCRC's Guaranteed Inpatient Revenue (GIR) system has never been promulgated as regulation, leaving hospital participation technically on a voluntary basis.

The HSCRC began setting rates in 1974, and in 1977 negotiated waivers from HCFA to permit Medicare and Medicaid participation. The nature of the waiver is unique among the four Medicare waivered states in several respects. First, the waiver formula has been written into statute through the efforts of the Maryland Congressional Delegation, and thus is subject to far less negotiation by HCFA.

Second, while the State must be able to demonstrate that its rate of increase in Medicare Part A payments does not exceed the national PPS rate of increase, the test is based on the
requirement that the aggregate rate in Maryland not exceed the national rate for the period from 1981 until the most recent date for which data are available. The state has had no difficulty meeting the waiver test because of the overall decrease in its costs per equivalent admission since 1981. Because of the waiver, Medicare contributes to the cost of uncompensated hospital care, something no other state now enjoys.

With only 50 acute hospitals to regulate, the HSCRC is able to provide a considerable amount of individual attention and negotiation. Two large academic medical centers, Johns Hopkins and the University of Maryland Medical Center, are the only major teaching institutions. Over time, the regulatory system has become less intrusive, focusing on macro level controls, and only conducting full hospital rate reviews when a hospital’s average charges per admission exceed a certain level. Between 1990 and 1992, the CRC conducted only 11 full reviews.

State officials are proud of the system’s record in reducing overall inpatient costs and in meeting other key goals. In 1992, the State’s cost per equivalent admission -- which was 24 percent above the national average in 1976 -- was pegged at 11 percent below the national average, according to AHA statistics. Cost shifting has been substantially reduced and unlike most other states, payers actually pay listed charges for services provided at Maryland hospitals. Hospital uncompensated care has been generously provided within the system, increasing from $36 million to $438 million from 1977 to 1993, representing about nine percent of hospital revenues.

Unlimited discounting between hospitals and payers is not permitted. Rather, only a four percent discount off charges is available to any insurer who meets nine criteria requiring coverage to be comprehensive, with low co-payment provisions, and provided to high-risk groups and individuals. A six percent discount off charges is provided to Medicare and Medicaid. Despite this control, HMO growth in Maryland has been the third highest in the nation, after Massachusetts and California.

Looking to the future, state officials are exploring means to reduce the rate of growth in physician and prescription drug costs that have been deemed to be unacceptably high. A state version of RBRVS for physician payment is currently under development, as well as a companion agency, the Health Care Access and Cost Commission, empowered to provide oversight of non-hospital provider charges and to initiate insurance reform (created by H.B.1359 of the 1993 Session of the General Assembly).

The State has already conducted small group insurance reform for employers with 2-50 employees. While Maryland has the highest number of mandated benefits in the nation, their new Standard Benefits Package is exempted from the requirements,
leaving non-group subscribers as the only group subject to the mandated benefits.

Regulators view the recent deflation in health care costs as an invitation to tighten the incentives within the rate setting system, seeking especially to lower the average length of stay and the volume of admissions. The HSCRC is also experimenting with new regulatory innovations: allowing hospitals to become fully capitated systems; permitting hospitals to receive capitated payments for distinct services; and exploring the formation of community networks. Treatment of non-acute hospitals is also under review for future action.

In summary, Maryland policymakers seem committed to the path of regulation, even looking to expand its scope to other elements of the health sector. They do so seeing regulation and competition as compatible and not rivals. They view capitation as a potential evolution in their model, and not as a contradiction. They see, however, that continuation of the Medicare waiver is critical for the future stability of their system.

A recent MHA report summarizes this attitude: "...Maryland will want to control its own destiny in health care reform and it desires to continue the now quarter century approach of payment systems embodying the principles of equity, access, and accountability in contrast to one dominated by the vagaries of open market forces. In all likelihood, this will be manifested by an effort to maintain a Maryland Waiver from the provider payment aspects of the next generation federal system." (Ashby 1994)

2. MASSACHUSETTS

If Maryland's rate setting system would be viewed within its borders as an example of regulatory success, judgements on Massachusetts' version would come closer to the definition of regulatory failure.

Unlike Maryland which has maintained one general enabling statute since rate setting's inception, the Massachusetts program involved a series of statutes with sunset clauses, each altering the system in significant, and sometimes dramatic ways. Unlike Maryland, which left the details of regulatory formulae to a professional commission, Massachusetts chose to craft statutes that incorporated and solidified the dense and complex prescriptions that often make up rate setting formulae and rules.

Massachusetts was one of the first states to receive a waiver from the federal government to have hospital Medicaid rates that were different from Medicare rates, beginning in 1974 with a prospective per diem methodology with occupancy minimums. In
1975, in the midst of a serious state fiscal emergency and fast rising Medicaid costs, the Legislature gave authority for the state Rate Setting Commission to control hospital charges. While evidence is available documenting a slowdown in the rate of growth of charges relative to national trends during the first five years, concerns were expressed about continued cost shifting to commercial insurers as well as the unshared costs of uncompensated care.

In 1982, the Legislature approved a stringent all-payer rate setting system that sharply narrowed the differences among payers, and obtained a federal waiver to permit Medicare participation. During this period, a statewide uncompensated care pool was created that shared expenses among all payers via a uniform surcharge on all inpatient hospital charges. In 1985, fearing threats from HCFA that the State would be unable to meet the requirements of the Medicare waiver test, and recognizing generous reimbursement levels to hospitals in other states during the early years of the PPS system, Massachusetts hospitals dropped their support for continued Medicare participation; the system was continued as a "three payer wraparound" absent Medicare.

It was during this period (1982-1987) that Massachusetts’ rate setting model had its greatest success in reducing hospital costs relative to the national average, a success that was noted in much empirical literature on the topic (Robinson and Luft 1988).

Because the rate setting methodology was tied to a 1981 base year, many hospitals felt that the system did not fairly reflect their current market position and became increasingly dissatisfied with their treatment. Unhappiness led to a rally on the Boston Common in September, 1987 of more than 10,000 hospital workers chanting, "Cost containment has gone too far". A new reimbursement law, Chapter 23, also known as the Massachusetts Universal Health Care Law because of its access provisions, included many features to appease hospital concerns, including special adjustments for Medicare shortfalls, enhanced reimbursement for staff salaries, a "low cost adjustment" for 40 community hospitals, and more. Because of these provisions, the State’s progress in constraining inpatient costs was eroded during the ensuing years.

Also, in a concession to the business community, private sector contributions to the uncompensated care pool were capped at about $300 million under Chapter 23, a cap which has remained substantially unchanged since 1988, bringing the average uncompensated care surcharge from approximately 13 percent to less than seven percent.

The Chapter 23 hospital finance provisions had a sunset of
governorship with a marked orientation toward deregulation and
market approaches across many government sectors, including
health care. His early interest in rate setting deregulation was
shared by many affected parties.

Blue Cross’ statutory seven and one half percent discount off
charges, negotiated in 1982, became a disadvantage when compared
with HMO discounts of much greater magnitude. (Unlike systems in
Maryland, New Jersey, and New York, the Massachusetts model
permitted unlimited HMO discounting). HMO’s, by 1991 a major
force in the Massachusetts market, were fearful of being drawn
into a future rate setting scheme. Blue Cross was also
determined to be freed from its statutory obligation to negotiate
a master contract with all acute hospitals. Hospitals continued
to be dissatisfied with discrepancies in allowable charges among
different classes of institutions. Business was increasingly
confident in its ability to negotiate sizable discounts directly
with hospitals. And the state was eager to use its bargaining
strength to negotiate much deeper discounts for its Medicaid
population than the rate setting system allowed.

This convergence of interests accompanied a deep sense of
"regulatory fatigue" on the part of legislators and regulators.
The Senate Chairman of the Legislature’s Health Care Committee
declared in a public hearing that it was time to put all the
hospitals together "like scorpions in a bottle" to see who comes
out alive. The result was legislation passed in late 1991
(Chapter 495) that: 1) ended the hospital rate setting system
after two years of weak transitional controls, 2) continued the
capped uncompensated care surcharge, but only for free care and
emergency bad debt, and 3) included small group insurance reform.

The aftermath of deregulation has seen significant merger,
consolidation, affiliation, and downsizing activity among hospi-
tals and health plans, most prominently Mass. General and Brigham
& Women’s which announced a planned affiliation in December,
1993. The State’s Medicaid program has moved aggressively to
place most of its recipients in managed care programs and to
contract for services. Mass. Blue Cross has also moved quickly
to transform itself into a managed care organization. A coal-
tion of public and private payers has joined forces to pressure
managed care organizations to keep rate increases down. The Rate
Setting Commission’s role in hospital finance has evolved into
one that solely consists of data gathering and dissemination.

Because this activity occurred at the same time as the
national moderation of health care inflation, it is difficult to
draw long term conclusions from this recent activity. Most
observers agree that the reconfiguration of the state’s health
care landscape is far from complete.
3. NEW JERSEY

As was the case in Massachusetts, political change helped to open the window of opportunity that led to deregulation in New Jersey. Though in the former it was a change in control of the executive branch, in New Jersey it involved change from Democratic to Republican control of the State Assembly, combined with an adverse ruling in a federal ERISA lawsuit. Prior to deregulation, the rate setting system was assumed by many to be solid and in little danger of elimination.

The New Jersey model had prominence. Begun in the mid-1970s to regulate both Medicaid and Blue Cross charges, the system evolved in the late '70s to regulate all payers, and with federal encouragement and support, became the laboratory to test the concept of "diagnosis related groups" as a new prospective reimbursement tool. Until December, 1988, the New Jersey system operated with a federal waiver permitting Medicare payments to be made under the state's regulatory system.

The New Jersey system was able to demonstrate positive results in cost containment. Between 1980 and 1990, inpatient costs increases per adjusted admission were less than the national average each year (147 vs. 167% over the decade), though less so during the second half of the decade. Hospital staffing levels were lower, and occupancy levels were higher than national norms. (Siegel 1994)

But dissatisfaction with the system mounted from a variety of perspectives. Many of the State's 85 acute hospitals felt that they could perform better in an open market. Consumers did not understand the difference between hospital charges and the DRG payment levels; because charges were routinely printed on bills, consumer anger was directed against the system by the significant number of patients for whom charges were not as high as the DRG rates.

But most important was the issue of uncompensated care which had risen by 1989 to about $900 million, with a surcharge cap of 19.5 percent. This heavy financial shift led a group of union welfare funds to sue in federal district court (United Wire et al. v. Morristown Hospital et al.), challenging a number of elements of the rate setting system, including the treatment of uncompensated care, as violations of the federal ERISA law. In May, 1992, a federal district court found for the plaintiffs, triggering a political crisis. The political environment had already been disruptive: Republicans won control of the State Assembly in the fall of 1991 following a major increase in State taxes proposed by Democratic Governor James Florio.

Though the ERISA decision was reversed by the U.S. Circuit Court of Appeals on May 14, 1993, the state had already acted to
change fundamentally the existing regulatory scheme by passing three interconnected laws, New Jersey’s Health Care Reform Act and Individual and Small Group Health Insurance Acts on November 30, 1992.

The Health Care Reform Act (Chapter 160, P.L. 1992) eliminated the rate setting system that had been in effect since 1980. A cap on hospital revenue was effective for 1993 allowing a transition year prior to total deregulation in 1994. Uncompensated care and Medicare shortfall funds were taken out of the hospital charge structure and set up explicitly as a subsidy program funded from a surplus in the State’s unemployment insurance trust fund.

The subsidies phase down over three years from $600 million in 1993 ($500 million for UC, $100 million for Medicare shortfall), to $517 million in 1994 ($450 million for UC, $67 million for MS), to $453 million in 1995 ($400 million for UC, $33 million for MS). Uncompensated care allowances can only be used for free care, not bad debt. Also, if the available funds in the unemployment trust fund drop below $1.5 billion, an automatic 0.62 percent payroll tax is triggered -- a requirement that Gov. Christie Todd Whitman is seeking to amend. No source of funding has been identified as of yet to provide subsidies after 1995.

The other major reforms involved individual and small group insurance reform. For individuals, five standard benefit packages were created, all governed by community rating rules, with guaranteed enrollment, a 75 percent loss ratio, and a one time 12-month waiting period for pre-existing conditions. A newly established Individual Insurance Health Board monitors the system which went on line in August, 1993, and has provided coverage to 90,000 individuals, about half of whom had no insurance coverage in the recent past. Because the program maintains no control over premium hikes, a recent decision by a major payer to raise rates by about 52 percent has raised serious concerns.

Small group reform has moved more slowly, with a phase in of a standard benefits package for groups of size 2 to 49, and a 300 percent community rating band adjustable by age, sex and geography. A separate Small Employer Health Board governs this program. Observers of this program have been surprised by the number of employers with fewer than 50 employees who self insure.

Finally, a Health Access Program was included in the reform package to provide subsidized payments to individual insurance purchasers available on a first come, first serve basis to uninsured individuals and families. Funding was legislatively set at $50 million in 1994, with an additional $50 million each year until 1997 when the funding is scheduled to reach $200 million. One estimate pegs the amount of subsidy available at $250 per uninsured individual if full funding is achieved in 1997.
(Cantor 1993).

Since deregulation, the New Jersey market has seen rapid change in hospital merger, affiliation, and consolidation activity, similar to that experienced in Massachusetts. New Jersey was the one major rate setting state whose HMO penetration rate was below the national average; the state is now experiencing a rapid growth in managed care development. Hospitals in 1993 reported no lack of solvency. Though Medicaid still pays for hospital services using DRGs, most other payers are now paying charges, with managed care winning sizable discounts.

4. NEW YORK

New York was the first state in the nation to employ mandatory prospective rate setting, starting in 1969 for Medicaid and Blue Cross. The 1975 fiscal crisis created concern about both Medicaid and broader health spending that led Governor Hugh Carey to seek systemwide controls; limits on commercial charges were added legislatively in 1978 to the rate setting mandate.

In 1983, the first New York Prospective Hospital Reimbursement Methodology (NYPHRM) was enacted, creating an all-payer inpatient reimbursement system that included Medicare. Like Massachusetts, the statute was long, and included all standards, factors, and formulae. NYPHRM I had a three year life, paid hospitals on a per diem basis linked to the 1981 base year, established New York's first direct mechanism to reimburse for bad debt and charity care, and included generous adjustments for hospital payment increases. NYPHRM II (1986-1987) adjusted the system to the loss of Medicare participation and tightened hospital payments while retaining a per diem system. NYPHRM III (1988-1990) moved all non-Medicare payers to case-based reimbursement, began to use the rate setting mechanism for insurance experiments and other initiatives, and revised standards for HMOs to negotiate contracts below charges. NYPHRM IV (1991-1993) and NYPHRM V (1994-1995) continued the case based system but included adjustments to reflect new costs, and introduced broader insurance and delivery reforms.

Critical to understanding the New York approach is to recognize that cost containment was only one of a series of explicit programmatic objectives. Other objectives included improved access for the uninsured, support for distressed hospitals, graduate medical education funding reform, expanded children's health coverage, encouragement of primary care and more. Each of these objectives has helped to shape New York's unique system. Other rate setting states used their systems to meet other programmatic goals, but none to the extent done in New York.
The cost of care to the poor and uninsured was financed through a system of pools in which money collected from add-ons to inpatient rates was used to finance both inpatient and outpatient hospital care for the poor and uninsured. Eight regional bad debt and charity care pools were created and financed by surcharges on third party payers. Expansion of children's health services was established and broadened under NYPHRM III and IV with the creation of the Child Health Plus program permitting families with uninsured children to buy basic primary and preventive health coverage for any child under the age of 13; the program initially was financed with subsidies of up to $20 million annually from the Statewide bad debt and charity care pool. About 83,000 children were enrolled as of September, 1994.

NYPHRM IV divertd some reimbursement funds to expand primary care services through grants to selected hospitals that fostered coordination and linkages among primary care providers. NYPHRM V expanded this effort to fund non-hospital primary care providers. Policymakers also used the rate setting program to provide funding for graduate medical education programs that encouraged residents and interns to enter primary care programs. Beginning with NYPHRM IV, most acute hospitals were required to establish "community service plans" to analyze the communities they served and to develop better plans to meet community health needs. NYPHRM V also authorized creation of "rural health networks" to improve access and service in rural parts of the State.

Evaluations of NYPHRM I-V suggest that the State has succeeded in meeting its various objectives under the laws. Inpatient costs have grown at rates less than the national average during most of the years 1980 to 1991, 9.3 percent per year in New York as compared with 9.9 percent for the nation. The control exercised by the State Administration and the Legislature has permitted the rate setting system to channel funds to meet its panoply of other objectives related to access, primary care, and other needs. One recent evaluation of the New York system concluded that "the most important lesson is that the regulatory approach, if pursued with vigor, can achieve a variety of goals -- including support for distressed hospitals and increased access to care as well as cost containment" (Jacobsen 1994).

The relatively heavy hand of regulation in New York can be attributed to a unique political culture that supported governmental approaches to policy problems, as well as long standing and consistent support for the NYPHRM model by key actors that have included: former Governor Mario Cuomo and his Department of Health, leaders of the State Assembly and the State Senate, Blue Cross, commercial payers, and local governments. While the hospital community has been somewhat divided due to opposition from suburban institutions, the Healthcare Association of New York State (HANYS) has supported the program to meet the needs of distressed hospitals and to promote access for the uninsured.
But in 1995, the continuation of hospital rate setting is at a crossroads because of circumstances similar to earlier developments in both Massachusetts and New Jersey. As occurred in Massachusetts, a newly elected Governor, George Pataki, prefers market mechanisms to government regulation, and opens the possibility that deregulation may be considered. The sunset of NYPHRM V at the end of 1995 presents the open window of opportunity to consider other approaches to the problems of health care access and cost containment. A fiscal crisis that features Medicaid as a principal target of opportunity for cuts completes the analogy.

As occurred in New Jersey, a federal ERISA lawsuit against key elements of the rate setting system opens the possibility that the system may be overturned in the courts. Oral arguments were heard before the United States Supreme Court in January, and a decision is expected in the spring of 1995. Also, some elements of the New York system are protected by a special national tax law provision (162N of the Internal Revenue Code) which prevents employers from deducting the costs of employee health insurance coverage unless they comply with the New York rate setting legislation. This provision was obtained in 1993 by New York Senator Daniel Patrick Moynihan; extension of this provision was recently extended to December 31, 1995, though any more extensions beyond that date appear unlikely.

Beyond these legal and political concerns rests a concern that the system itself is becoming increasingly burdensome: "...the incentives are complex, shifting, and in places contradictory; the regulatory atmosphere limits the range of options hospitals can use to limit costs and focuses management decisions on gaming the system rather than reconfiguring health care" (Jacobsen 1994).

The growth of managed care organizations in New York has created tensions similar to those that occurred in Massachusetts. HMOs seek the ability to pay hospitals less than charges mandated by the rate setting law, creating a disjunction between HMOs and all other payers. NYPHRM III permitted HMOs greater flexibility in negotiating discounts for inpatient care for the first time in the state, allowing them to obtain better prices than either Blue Cross or the Medicaid program. The uneven treatment contributes to the financial instability of the Blue Cross plans, and undermines the rationale for the rate setting system.

The convergence of events suggests that 1995 -- instead of being a year for what some foresaw as minor NYPHRM adjustments -- could well be a momentous year for health policy in New York.
III. ISSUE DISCUSSIONS

1. COST CONTROL

A review of relevant literature as well as discussions with key state officials indicates a fairly consistent finding that mandatory rate setting can work to control per diem and per case costs when pursued with vigor. As the RAND study of the New York system concludes, this finding should not come as a major surprise: "The state, after all, is deciding how much hospitals will be paid per unit. If the unit price is set low enough, payer costs will be contained by definition" (Jacobsen 1994).

The Maryland system seems to have enjoyed the greatest success in reducing its costs relative to the rest of the nation, from 24 percent above the national average in 1976 to 11 percent below the national average in 1992. This decline has been consistent over the history of the program (Ashby 1994). New York’s model has also enjoyed a high degree of success in restraining the growth of their inpatient hospital costs, though not in the consistent fashion experienced in Maryland. During periods when other programmatic objectives such as access expansion and aid to distressed hospitals took precedence, the diligence in holding down costs has not always been a priority.

The Massachusetts program demonstrated a strong capacity to rein in costs during its early and all-payer years, 1975 to 1985. During its final four years, under Chapter 23, controls were loosened so greatly that the system itself became viewed in the eyes of many as the culprit of hospital cost inflation. New Jersey policymakers could rely on data showing a consistent finding that costs grew less than the national average during the 1980s; however, the difference narrowed substantially during the latter half of the decade as hospital labor costs increased, while other problems such as the size of its uncompensated care pool became an object of concern.

The evidence regarding the success of rate setting in holding down per capita hospital costs and per capita health care costs is less conclusive. These data are important to allay fears that rate setting’s success in holding down per admission costs could be explained by a shifting of care to other health care services and providers. There are far fewer studies in these categories, and even fewer that provide state specific information. These studies do exist, and do point to lower per capita spending increases in the mandatory rate setting states. But rate setting has been far less an object of research in recent years and data on its performance since 1985 is sparse.

Rate setting was created in a period when the inpatient hospital setting was engine of most health care spending. When NY’s NYPHRM model began in 1983, its regulation affected about 65
percent of the State's health care premiums as compared with between 35 to 40 percent today. The shift to outpatient care and to other alternative settings has lessened rate setting's once considerable clout over the direction of the overall system. Rate setting may have had some impact in pushing this trend as cost containment pressures increased, but no studies have examined rate setting's role in this area.

2. IMPACT ON PAYERS, PUBLIC AND PRIVATE

The impact of state rate setting on all payers has shifted with the passage of time. This has certainly been true in the case of Medicare. From a position in the 1970s when states were actively encouraged and supported in their efforts to create all payers systems, HCFA moved during the Reagan Administration to discourage these programs, despite Congressional support. Massachusetts (1985), New York (1985), and New Jersey (1988) all gave up their Medicare waivers.

In the cases of Massachusetts and New York, hospitals were eager to give up the waiver during the early years of the Prospective Payment System when federal reimbursements were especially generous. As federal policymakers moved to tighten Medicare reimbursement levels in later years, that system is now far less inviting -- and no invitations by HCFA to reestablish all-payer systems have been forthcoming or are expected.

Maryland policymakers were both wise and fortunate to secure their Medicare waiver in federal statute, leaving it far less open to alteration by HCFA officials. While it has been modified over the years, it has also been zealously guarded by the Maryland Congressional delegation who recognize that the waiver formula brings far more funding into the State than would be the case were its hospitals to operate under PPS.

Medicaid's role in rate setting has also evolved since the mid-1970s when some rate setting models were established to control public spending in the midst of a severe recession. By fixing Medicaid reimbursement to a fixed percent of charges (less than Blue Cross or commercial payers), rate setting provided a degree of predictability and savings that satisfied the objectives of both public and private payers.

But some rate setting models have failed to control utilization, and also permitted forms of gaming, particularly in Massachusetts. When the Massachusetts Legislature established a statutory mandate in 1990 to enroll all Medicaid recipients in managed care plans, state Medicaid program administrators began looking for relief from the rate setting reimbursement requirements. Because HMOs were increasingly able to negotiate hospital inpatient discounts of 30-40 percent for private payer hospital
contracts, the rate setting model seemed less useful. Massachu-
setts Medicaid agency leaders became deregulation advocates in
1991 as they sought to implement their managed care mandate by
contracting on their own for inpatient hospital services. New
York and New Jersey policymakers are now also moving aggressively
to increase their Medicaid managed care enrollment.

In Maryland, the Medicaid and Medicare programs pay 94
percent of charges, the deepest discounts available to any payers
in that state, public or private. While there are initiatives
underway to enroll Medicaid recipients into managed care, there
are no plans to seek special discounting authority for the public
authorities.

Private payers also have been affected in dramatic ways by
changes in the rate setting environment. Blue Cross plans have
played unique roles in each state since the 1930s, through their
non-profit status and special role as insurer of last resort.
Plans in Massachusetts and New York have faced severe financial
and organizational crises in recent years. The special privi-
leges granted to each plan have been eroded by competition from
HMOs and other new organizational forms. Private payers are no
longer as willing to share in financing the cost of uncompensated
care for uninsured citizens.

The Massachusetts and New Jersey Blue Cross plans are now
transforming themselves into managed care organizations, moving
out of indemnity insurance as rapidly as possible, and supporting
the new deregulated environment. The future role of the Maryland
and New York plans is far less certain. Plans in both states
have maintained positions in support of continued rate setting
regulation.

Commercial insurance has historically played an important
role in the development and support of all payer rate setting.
HIAA was one of the key organizations promoting this form of
regulation throughout much of the 1980s. But HIAA has been
battered by internal divisions, and lost four of its largest
members (Aetna, MetLife, Prudential, and Travelers formed their
own organization, the Alliance for Managed Competition in 1992)
in disagreements over the role of managed competition and managed
care. HIAA has not officially abandoned its support of hospital
rate setting, but neither does it actively promote the concept.
The HIAA affiliate in Massachusetts opposed -- though not
aggressively -- deregulation in 1991. The commercial industry in
Maryland, bucking the national trend, continues to support the
all payer system.

3. MANAGED CARE

The greatest threat to the principles of hospital rate

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setting has emerged in the concept and form of managed care. Indeed, if mandatory rate setting was the principle operating paradigm for controlling hospital costs in the 1970s (Anderson 1991), it has been replaced by managed care as the paradigm for controlling health care costs in the 1990s. Whether managed care will live up to this promise is beyond the objectives of this report. But its role in toppling some forms of state based rate setting is instructive.

Of the four state systems covered in this report, the Massachusetts version was unique in one critical respect -- from the inception of the all payer model in 1982, the State permitted HMOs to negotiate unlimited and unregulated discounts for hospital services. The other three states all kept HMO hospital agreements within the purview of their regulatory structures. Maryland, for example, permitted any payer, including HMOs, to obtain discounts off charges of no greater than four percent, and only in exchange for meeting certain conditions such as open enrollment (currently, less than one half of Maryland HMOs take the discount).

Why did Massachusetts choose this path? According to the current executive director of the Massachusetts Association of HMOs, state industry leaders used their influence in Washington in 1982 to block a Medicare waiver from being issued to the State unless HMOs were explicitly exempted from the rate setting system. With many issues on the table, state officials negotiating a new hospital finance law paid little attention at the time to the impact of this design feature in light of the fact that HMOs in 1982 represented a tiny proportion of the market.

By 1990, HMO penetration in Massachusetts was among the highest in the nation; while commercial indemnity insurers paid 100 percent of hospital charges, and Blue Cross, the largest player in the market, was tied to a statutory 92 1/2 percent of charges, HMOs were able to negotiate discounts of 30 to 40 percent or more. As Blue Cross faced up to a severe financial and organizational crisis, its leaders urged state policymakers either to bring HMOs into the system on an equal plain, or else to free Blue Cross to compete with them on an even footing. The prospect of attempting to force HMOs into a rate setting model was considered to be a political impossibility.

Of the major rate setting states, New Jersey was the only one that had an HMO penetration rate that was below the national average throughout the 1980s and into the early 1990s (GHAA 1993). Discounting and special contracts between hospitals and HMOs were not permitted. As such, there is not much indication

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6Personal conversation with Robert Hughes, MAHMO.
that conflicts surrounding managed care had much to do with the deregulation decision in 1993. Nonetheless, the lifting of the rate setting system in 1993 has been accompanied by a rapid explosion in HMO enrollment across the state. As contracting and networks proliferate, capacity issues stand as the major impediment to faster growth. The State is also moving aggressively to expand its Medicaid managed care program. As the size of the managed care industry increases, the state is looking to rewrite its HMO regulations, to initiate report cards, and to grapple with provider pressures for "any willing provider" laws.

Following adoption of a DRG payments system in New York in its 1988 NYPRHM model, HMOs began to increasingly exercise the option to negotiate hospital discounts though there was still a requirement for Department of Health approval. DoH has taken the general position that hospitals are "consenting adults" who would not enter a contract that would harm them, but the change has created a situation increasingly analogous to the 1991 Massachusetts situation. HMOs now frequently pay less than Blue Cross, commercial payers, and the Medicaid program, depleting dollars that have been used to subsidize uncompensated care, access programs, and other special initiatives. Hospitals fear an inability to compete in risk bearing, capitated programs because of financial losses sustained during the more severe phases of NYPRHM (Jacobsen 1994).

Maryland, again, represents the exception. Much theoretical literature in the early 1980s hypothesized that strict rate setting would discourage the growth and development of HMOs. The above average rate of growth of HMOs in all rate setting states except New Jersey negates the bulk of that argument. The example of Maryland would appear to destroy it. Maryland claims one of the highest rates of HMO growth among the 50 states in a jurisdiction which permits no special hospital discounting.

Legislation has been proposed in past years in the Maryland Legislature to permit managed care discounting, but has been opposed by the Maryland Hospital Association and others. Because regulators have already accounted for savings from shorter lengths of stay, no benefit is seen in allowing more discounting. Policymakers believe that HMOs should compete by managing the care of patients better, not by using market power to lower their rates. The State's principal difficulty involves the special geographic relationship to the Washington, D.C. hospital market, where discounting is allowed, and from where many Maryland patients receive services. The border issue creates many unique problems, the relationship between managed care and rate setting being only one.

Despite Maryland's unique marriage of rate setting and managed care, in other states the relationship has been uneasy and destabilizing. Whereas rate setting focusses only on inpa-
tient care, managed care brings in the larger health environment, including outpatient, physician, home health, and more. Whereas rate setting seeks equity among payers, managed care in most settings celebrates bargaining, contracting, and hard competition. Whereas rate setting involves single rates of payment -- whether per admission, per diem, or per discharge -- managed care is more adaptable to capitation. On all of these counts, and others, managed care has a distinct advantage over rate setting as the operating paradigm for the 1990s.

What remains unclear is the lesson or lessons to be learned from the Maryland model for the rest of the nation -- whether their experiment, which places managed care in a rational, regulatory, consensus environment can be ultimately more successful than managed care in the brave, harsh, and confrontational world of health care competition.

As larger portions of the health sector move to capitation, interest in the experience and lessons of rate setting actually are increasing. Maryland’s current experiments with new forms of capitation within a rate setting model may hold important lessons for policymakers in the years ahead. Both traditional rate setting and capitation face some common conceptual difficulties -- namely, how to structure incentives to induce efficient and high quality behavior on the part of providers. In this light, Maryland’s experiments with rate setting and capitation merit special attention.

4. ACCESS FOR THE UNINSURED

As mandatory rate setting systems exerted greater controls against cost shifting, hospitals sought means to recover costs for bad debt and charity care that payers increasingly refused to meet. In response, policymakers in rate setting states created uncompensated care pools: 1) to provide equitable financing from all payers; 2) to distribute these funds in a fair manner to hospitals that provided significant amounts of such care; and 3) to provide a safety net of coverage for growing numbers of uninsured individuals. These pools became one of the more characteristic features of mandatory rate setting, and have been viewed as successful (Hsiao and others 1986) (Thorpe 1987).

The precise systems vary from state to state and have changed over time. Maryland’s system permits a percentage markup to all rates for bad debt and charity care based on hospital specific standards of reasonableness. The cost has risen from $36 million in 1977 to over $438 million in 1993, or about nine percent of hospital revenues. In 1992, state officials recommended the creation of a pooling mechanism to share funds among hospitals; but this recommendation has been delayed pending the resolution of federal ERISA suits from New York that may determine the ability of states to continue these funding tools.

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Massachusetts created its uncompensated care pool in 1984 to fund both bad debt and charity care. It began to grow rapidly and uncontrollably from about $165 million in 1984 to over $300 million in 1987. In exchange for support from large business groups for the 1988 universal health care law, policymakers agreed to cap private sector pool contributions at about $300 million where it has remained ever since. Private sector surcharge levels have dropped from about 13 percent in 1988 to under seven percent today. As part of the 1991 deregulation statute, the pool was changed to cover only charity care, and not bad debt. Hospitals complain that the pool covers less and less of their charity care needs. They are concerned that current health reform discussions in Massachusetts involve taking large portions of the pool’s funding and using those monies to finance insurance coverage for uninsured residents.

Changes in the New Jersey uncompensated care program have paralleled those of Massachusetts. The New Jersey pool also was funded by a surcharge on hospital charges. By the time of the federal lawsuit, the surcharge amounted to more than 19 percent on hospital bills, for a total of more than $900 million in funds. The high levels of the surcharge (as compared with those in Massachusetts, for example) contributed to the pressure for the lawsuit. The new system, created under the deregulation legislation, covers only charity care and emergency bad debt, is funded from the state’s Unemployment Insurance Trust Fund, and is scheduled to drop in total funding from $500 million in 1993 to $300 million in 1997. State policymakers intentionally plan to shift resources away from hospital reimbursement and toward insurance coverage for needy individuals and families.

In New York, NYPRHM created a series of regional bad debt/charity care pools along with a special public hospital pool to address specific concerns that revenues would be shifted from upstate to New York City or from private to public hospitals. While uninsured visits to New York hospitals have clearly increased because of the pool, the mechanism was not the most efficient means to provide services to the uninsured. Thorpe notes that only about $4 worth of additional care was provided to the uninsured between 1982 and 1985 for each $10 in pool revenue (Thorpe 1988). But more politically palatable means to finance uninsured care would have been difficult to achieve. The fate of the New York pool is awaiting a U.S. Supreme Court decision in the spring as to whether the pool’s funding mechanism violates the federal ERISA law.

The experience of these four states suggests two lessons:

First, no necessary connection exists between deregulation and the dismantling of support for uncompensated care. Massachusetts and New Jersey both maintain structures to provide continuing support albeit at much tighter and stricter levels. Massa-
chusetts' tightening stance actually began during its Chapter 23 regulatory period. Nonetheless, it is also clear that deregulation in both states was accompanied by a lessening commitment to this funding mechanism.

Second, provision of uncompensated care subsidies to hospitals is not the most direct way to cover the uninsured. The pools were initiated to address hospital financial concerns first, and the needs of the uninsured secondarily. Both Massachusetts and New Jersey are now exploring means to use these funds to directly insure individuals and families. New York has also used system funding in a variety of innovative ways to increase access, especially for children. Efforts to shift the focus from institutions to individuals are expected to continue.

5. INSURANCE REFORM

Because all four states have undertaken significant insurance reform initiatives (along with approximately 40 other states), it is reasonable to suggest that neither continued regulation nor deregulation is a particular incentive or impediment to insurance market changes.

All four states have undertaken small group insurance market reform, and their differences in approach are not markedly different from initiatives taken by other states. The most striking reform in this area has been New York's move in 1992 to establish uniform community rating for all individual policies, Medicare supplemental policies, and all policies for groups of 50 of fewer. Unlike community rating laws in other states, no variation in rates is permitted at all. Early results indicated some drop in individual policies by healthier enrollees, a result that policymakers in Washington noted frequently during the 1994 reform debate. More recent results have called into doubt those earlier assessments. Most importantly, because the community rating law involves a risk adjustment mechanism administered by the State, the future of this law could be jeopardized by the pending federal ERISA lawsuit affecting the New York rate setting law.

Both Massachusetts and New Jersey carried out their first efforts at insurance reform as part of their deregulation initiatives. This seems to have been more of a political judgement than a legal or administrative necessity. Features of insurance reform laws in all states have included modified community rating, guaranteed enrollment, standard benefit packages, fixed loss ratios, and regulation of pre-existing conditions clauses.

If there is any lesson to be learned from the four states in the context of mandatory rate setting, it is that there is no necessary connection between rate setting and insurance reform, good or bad. Maryland and New York have undertaken reforms at
least as extensive as those in Massachusetts and New Jersey.

6. INFORMATION SYSTEMS

All four states seek to address information needs for the public and private sector, though the needs vary markedly from state to state.

Since 1973, Maryland policymakers have relied on comprehensive cost, revenue, and output data submitted according to uniform cost centers. Since 1977, this information has also included case mix data in the form of standardized discharge abstracts for each patient. The State's Health Services Cost Review Commission collects and processes the data, producing one of the most detailed and complete hospital data bases in the country. The State's new Health Care Access and Cost Commission is now assuming responsibility for data collection for the non-hospital provider communities.

The New York Department of Health has also made collection and analysis of data at the institutional and departmental level a priority matter. Issues surrounding data involve its completeness, especially regarding outpatient services, and its equal accessibility to all interested parties. DoH has taken a lead in development of an electronic claims clearinghouse, funded as a demonstration program by the Robert Wood Johnson Foundation, linking a subset of hospitals into an electronic claims processing network. DoH has also used data to drive an incident reporting quality initiative on adverse inpatient events. In 1993, Governor Cuomo established a Quality Improvement Initiative to identify areas for the development and implementation of practice guidelines.

Both the Massachusetts Rate Setting Commission and the New Jersey Department of Health had their own systems for collecting and disseminating data on the operations of the rate setting systems. Both systems are now in disrepair, and policymakers are in search of the most relevant role for data and information in a deregulated health market.

The Massachusetts RSC recently produced a small area analysis of "preventable hospitalizations" to identify geographic regions where access to, or effectiveness of, primary and preventive care might be a problem. Commission analysts are development measures and data requirements to evaluate the impact and effectiveness of chapter 495, the deregulation statute. And analysts are also studying the uncompensated care pool to better understand who uses the pool and how it could be better utilized. More than three years after deregulation, though, RSC staff are still seeking the most productive role for their services. And other parties in and outside of government are also filling information roles in the new environment.
The New Jersey Essential Health Services Commission has been given broad responsibility to oversee the implementation of key elements of the 1992 Reform Law and to report to the Governor and the Legislature each November on areas such as Medicare and Medicaid payments, ways to encourage preventive and managed care, review of proposed malpractice reform, studies of hospital costs, charges and outcomes, and ways to help consumers make prudent choices. The development of these and other reporting goals is still underway.

IV. Conclusion

Perhaps the greatest anomaly of the rate setting story is the disjuncture between the states and the federal government. While a decided shift away from prospective rate setting can be observed among the states, the federal government has moved in a decidedly different direction. PPS reimbursement for Medicare hospital services, begun in 1983, represented the establishment of prospective rate setting for the first time on a national basis. Rather than stopping there, Congress and the Administration moved ahead in 1991 to establish prospective rate setting for Medicare physician reimbursement as well via RBRVS. Recently, HCFA officials announced their intention to develop a prospective rate setting model for hospital outpatient services.

While states have eagerly embraced forms of mandatory managed care for Medicaid recipients, the federal government has encouraged Medicare clients to join managed care programs solely on a voluntary basis; moreover, the numbers doing so have been small, and the program has been found to cost the federal government more than if those clients had stayed in the fee-for-service model.

Explanations for these differences are not hard to find. Elderly Medicare recipients are more likely to have established relationships with providers and are more difficult to force into managed care programs than AFDC mothers and children, both logistically and politically. The federal government has less flexibility to attempt uniform solutions when the penetration of managed care varies so widely across the nation. State governments have proven to be quicker and more adaptable.

The new leadership in Congress has given clear indications of a desire to force a stronger marriage between federal health programs and managed care; but for the moment, Washington, D.C. provides strong support for the prediction that prospective rate setting is far from finished as an important policy tool, even though it has been replaced at the state level -- not completely -- by managed care and capitation.

The implementation of managed care and capitation to date has
been consistent with the philosophy of the marketplace. These forms require all payers to fend for themselves. They permit states to look after their own internal problems -- particularly Medicaid -- without engaging in onerous and complicated regulation affecting private payers. They are, in short, more in tune with the tenor of the times.

A number of states have continued to use prospective rate setting in this new environment. Maryland, in particular, provides a critical exception, seeking to combine careful regulation with extensive managed care in a consensual and collaborative way. Their efforts stand remarkably and determineably alone. In the years ahead, they will continue to be our principal counterpoint to evaluate the competition-oriented, managed care direction in state health financing policy.
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Participants: Meeting of Rate Setting States
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