

Rising Health Care Costs: State Health Cost Containment Approaches

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EXECUTIVE SUMMARY

The rapid growth of health care spending is once again of deep concern to payers, purchasers, providers, the public, and policymakers. Efforts to control previous increases in health care costs have focused on the supply of services (Certificate of Need programs), the pricing of services (hospital rate setting), and the demand for services (managed care). In addition, states have often employed strategies aimed at controlling the price and business of health insurance. This paper focuses on lessons learned from cost containment efforts.

Controlling supply: Certificate of Need (CON)

States use CON to promote cost containment by decreasing both service duplication and investment in excess capacity. Under CON, certain health care providers must obtain state approval for substantial changes in their scope of services or for capital investments.

CON was one of the earliest attempts at cost control and characterized an era when governmental intervention was viewed as a necessary element of any cost containment effort. While some states allowed their CON programs to lapse when the federal enabling legislation expired, many chose to continue the program as one device in a range of cost saving strategies. Today, 38 states administer CON programs. Among the paper's key findings:

- Little data exists to demonstrate that CON helps curb overall health care costs. While it does have a demonstrated impact on the number of patient beds, intensity of services appears to counteract any cost savings realized;
- There is a demonstrated correlation between CON and the availability of indigent care, redirecting funds from investments in capital to subsidization of care; and
- CON may be useful in promoting regionalization of services, with a concomitant improvement in patient outcomes for selected, high-risk services.

Controlling costs: hospital rate setting

Most hospital rate setting systems were implemented to control the rate of cost increases in hospital care. Research reflects broad-based agreement that while rate setting was able to exercise considerable control over the cost per admission and over per capita hospital costs, it has not constrained the rate of growth in health care costs per capita. At the same time, the degree to which substitution of unregulated outpatient services for regulated inpatient services has occurred as a direct market response to cost containment is debatable.

The success of rate setting systems is dependent on several factors:

- statutory flexibility appears vital to the long term viability of any regulatory system, which must be able to adapt to a rapidly changing environment;

- rate setting systems must have the authority to limit payer discounts in order to avoid an erosion of the system created by the lopsided negotiating power of a few influential payers;
- there must be solid political support for the system; and
- the inclusion of all payers – including Medicare – under the rate setting scheme provides great strength to the system by minimizing cost shifting and maximizing equity among payers.

Controlling demand: managed care

Evidence of managed care's ability to constrain health care costs is mixed; it is not clear whether today's rising health care costs reflect a failure of managed care or simply the correction of a competitive insurance market flooded by underbidding.

Among the lessons that may be gleaned from the managed care experience:

- Managed care plans tend to provide comprehensive benefit packages with less out of pocket cost to the consumer, at a more attractive price;
- Consumers are generally satisfied with the financial aspects of managed care plans, but are less satisfied with the administrative features of the plan designed to control access to services;
- Managed care plans do impact utilization of certain services, but it is not clear that these plans adversely impact the quality of care;
- Privately insured (nonelderly) HMO enrollees generally have lower incomes than non-HMO enrollees, increasing their price sensitivity.

Because managed care consumers are attracted to and satisfied with their plans' financial characteristics and relatively dissatisfied with the organizational aspects of those plans, increased enrollee cost sharing will likely fuel growing frustration with managed care.

Other levers: insurance regulation

Controlling the cost of insurance is, like other regulatory strategies, a lever policymakers may employ as part of a comprehensive cost containment program. While this approach may not exercise a direct impact on the cost of care, it carries with it the possibility of a substantial indirect effect on the cost and viability of the current system. It is also important to bear in mind the possibility that market reforms have prevented or slowed erosion of coverage. While not proven, the importance of this potential cannot be ignored.

Where to now?

Today's cost containment strategies (increased cost sharing and limited benefit defined contribution plans, for example) mirror those of the past in that they tend to address only price or supply or demand. The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand, building a comprehensive, tripartite strategy that is sensitive to the

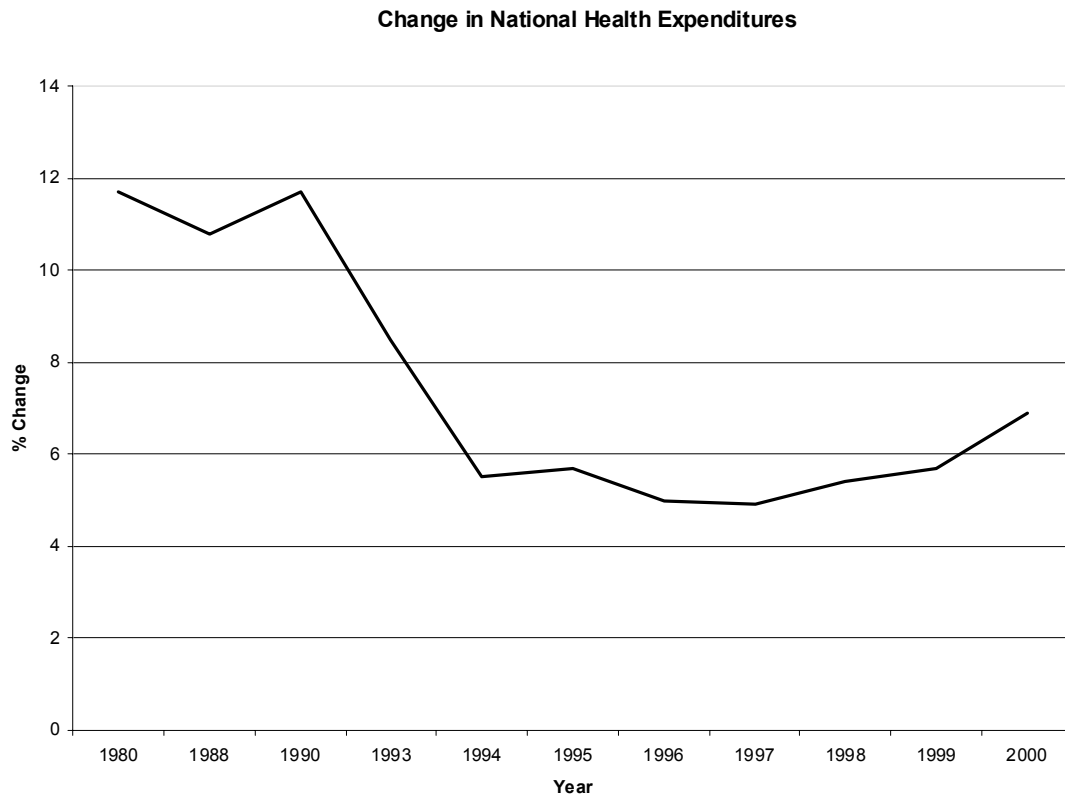
complexities and idiosyncrasies of the health care marketplace. Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them.

TABLE OF CONTENTS

Setting the stage: the case for cost containment	1
Where is the growth in costs coming from?	2
What can be done?	4
Controlling supply	6
Certificate of Need regulation	6
Impact.	8
Lessons learned.	11
Controlling costs.	12
Hospital rate setting.	12
Background.	12
Characteristics	15
Outcomes/impacts.	18
Rate setting and managed care.	21
Issues.	22
Lessons learned.	23
Controlling demand.	25
Managed care.	25
Background.	25
Characteristics.	28
Impact.	30
Access to care.	30
Utilization of services.	31
Quality.	32
Consumer satisfaction.	32
Cost.	33
Lessons learned and the future.	34
Other levers.	36
Regulation of health insurance.	36
Background.	36
Types of regulation.	38
Impact of insurance regulation.	43
Lessons learned and prospects.	45
Conclusion.	47
Where have we been?	47
Where are we headed?	48
Where to now?	49

SETTING THE STAGE: THE CASE FOR COST CONTAINMENT

The growth in health care spending is a topic of growing concern for payers, purchasers, providers, the public, and policymakers. National health expenditures increased at a rate of almost 7% in 2000, as compared to 5.7% in 1999, edging out the growth in gross domestic product by a slim margin, a reversal of a nine-year trend.¹



Data Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis

In total, health care spending in the US reached \$1.3 trillion in 2000, with higher than expected growth in public spending and growth in private spending below what had been expected by the federal government.² The Centers for Medicare and Medicaid Services anticipate sharp growth in public sector spending for Medicare, Medicaid and public health, in the near term; this growth is attributed to changes in Medicare/Medicaid law, increased Medicaid enrollment due to a

¹ *Highlights - - National Health Care Expenditures, 2000*. HCFA website. <http://www.hcfa.gov/stats/NHE-OAct/hilits.htm>.

² Heffler S, Smith S, Won G, Clemens MK, Keehan S, Zezza M. Health Spending Projections for 2001-2011: The Latest Outlook. *Hlth Aff*. Vol 21(2):207-218. March/April 2002.

slow economy, and investments in bioterrorism defense.³ The government also projects a marked acceleration in real private expenditures for health care as the result of rising household income, the loosening of restrictions traditionally imposed by managed care plans, and rising price inflation.⁴

Milliman USA projects even more striking growth, estimating an increase in per capita health care costs for all payers of 44% by 2006.⁵ Consumers are expected to shoulder the lion's share of this growth, seeing their costs increase by 55% between 2001 and 2006⁶ as employers – faced with a slowing economy and rising unemployment – become less inclined to absorb future increases in the cost of benefits.⁷

While the government is projecting an eventual slowing in the rate of growth in national health spending – reflecting slower increases in utilization, intensity of services, and input prices – that growth is still expected to outrun real economic growth.⁸ Health care will continue to consume a growing proportion of our fiscal resources. To simply maintain health care expenses at the 13.2% level of GDP observed in 2000⁹, we will have to spend approximately 4% less each year than projected.¹⁰ This presents an obvious challenge to state policymakers who strive to meet the needs of their citizens while preserving fiscal integrity and maintaining a balanced budget. Medicaid represents 20% of state budgets at a time when states are having to face the reality of slowing growth in tax revenues, forcing budget crises across the nation.¹¹

Where is the Growth in Costs Coming From?

The cost of hospital care exhibited marked growth in 2000, with the cost of inpatient care increasing by 2.8% and outpatient care by 11.2%. Taken together, inpatient and outpatient care comprised 43% of the cost increases in 2000.¹² Physician services comprised 28% of total growth - a smaller proportion than that observed in the prior year's rate (34%), but still substantial. Similarly, growth in

³ *id*

⁴ *id*

⁵ Diede ML, Lilledahl R. Health Care Cost Control: Getting on the Right Track. *Mgd Care*. 24-33. February 2002.

⁶ *id*

⁷ Dunks PJ. Will Consumerism Lead to More Price-Sensitive Patients? *MGM J*. March/April 2001. www.mgma.com.

⁸ *id*

⁹ *Trends and Indicators in the Changing Health Care Marketplace, 2002; Chartbook*. Kaiser Family Foundation. May 2002.

¹⁰ *supra* at 5

¹¹ Riley P. *State Health Policy Responses to Recessions (1970-2002)*. May 2002.

¹² Strunk BC, Ginsburg PB, Gabel JR. Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000. *Data Bulletin No 21- Revised*. Center for Studying Health System Change. September 2001.

spending on prescription drugs made up 29% of the increase, down from 35% the previous year.¹³

Levit and colleagues from CMS' National Health Statistics Group dissect the growth factors in a recent *Health Affairs* article.¹⁴ They cite systematic changes in public policy as significant cost-push factors. These changes include the creation of the State Children's Health Insurance Program (SCHIP), which provides expanded access to health coverage for low income children. SCHIP spending increased from \$1.8 billion in 1999 to \$2.8 billion in 2000; a portion of these increases is funded by the states. Medicaid expenditures rose as well.

At the same time, states have made use of the federal disproportionate share hospital provision, more commonly known as DSH. The DSH program was created in the late 1980s as a means of providing supplemental revenues to hospitals serving large numbers of low income patients, on the premise that such patients carry with them inherently higher costs. States were able to use the program to boost federal Medicaid spending without concomitant expenditures of state funds¹⁵ – provider “taxes” could be used to seed federal match. Although the DSH provisions have now been limited, states were able to temper the growth in their Medicaid spending by using DSH payments to supplant state funds. Still, total Medicaid expenditures increased by over 8% in 2000.

After a brief but significant downward turn in the rate of spending growth for nursing home care between 1995 and 1999, spending on long term institutional care rebounded in 2000; much of the spending for these services is attributable to Medicaid programs.

Medicare spending for hospital services climbed 4.5% in 2000, exhibiting the greatest increase since 1997.¹⁶ According to Levit, *et al*, this level of spending may be traced to legislative changes enacted as part of the Balanced Budget Refinement Act, which softened reductions in disproportionate share payments, reduced the gravity of cuts to graduate medical education funding and which temporarily boosted reimbursement to sole community provider hospitals. At the same time, the severity of illness exhibited by Medicare inpatients fell, pushing case mix adjusted reimbursement down. While hospital revenues overall grew in 2000, so did the cost of producing hospital services. These costs include wage pressures – particularly wages for nurses – increased sharply, as did energy costs. The cost of technology was also a major contributor to the increased cost of care.¹⁷

¹³ *id*

¹⁴ Levit K, Smith C, Cowan C, Lazenby H, Martin A. Inflation Spurs Health Spending in 2000. *Hlth Aff.* Vol 21(1):172-181. January/February 2002.

¹⁵ Coughlin TA, Ku L, Kim J. *Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s*. Urban Institute. January 2000.

¹⁶ *id*

¹⁷ Okunade AA, Murthy VNR. Technology as a “Major Driver” of Health Care Costs: A Cointegration Analysis of the Newhouse Conjecture. *J Hlth Econ.* Vol 21:147-159. 2002.

Accelerated growth rates in health insurance premiums have also characterized the past several years. Premium increases were attributable to the rising costs of benefits (driven primarily by prescription drugs) and a shift in enrollment to higher-cost benefit plans. A continued upward swing in the underwriting cycle also contributed to premium increases, as insurers sought to recover prior years' losses and build profitability.¹⁸

The recent build-up in dissatisfaction with restrictive managed care plans also contributed to spending increases. Not only have providers grown less willing to negotiate capitation rates that favor payers, but consumers increasingly opted for more expensive benefit designs that allow more choices.¹⁹ Seeking broader, more open provider networks, the number of individuals enrolled in health maintenance organizations began to decline for the first time in 2000.²⁰

What Can Be Done?

There is some evidence that growth in health care spending is the collective result of three factors: inefficiencies in the provision of health services; continued large returns to providers; and investment in new technology.²¹

Total spending includes both growth in the volume or units of service produced and the cost paid per unit. Payments are a function, at least in part, of the cost of inputs and resources used to produce the service. These dimensions of spending serve as the targets for cost containment strategies. That is, policymakers have focused on the supply of services, the pricing of services and the demand for services.

Efforts to control the **supply** of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort to promote the rational, planned development of health services and, most often, to hold down the volume of services provided and the cost (as related to intensity of service).

Hospital rate setting is a good example of a cost containment strategy designed to control the **price** of services provided, focusing on promoting the efficient production of services in one of the most costly sectors of the health care market. Rate setting is designed to impose limits on hospital revenues, making hospitals operate within a constrained budget. While individual programs vary a good deal,

¹⁸ *supra* at 12

¹⁹ *id*

²⁰ *HMO Enrollment Continues to Decrease*. Interstudy Publications. May 7, 2001. <http://www.hmodata.com/Pdf/ir111pr.pdf>. June 6, 2002.

²¹ Altman SH, Wallack SS. Health Care Spending: Can the United States Control It? In *Strategic Choices for a Changing Health System*, S. Altman and U. Reinhardt (ed.). Association for Health Services Research. 1996.

the overriding objective is to control hospital *charges* while striving to maintain a viable hospital system.

Managed care has grown to be the predominant cost containment strategy. Aimed at influencing the **demand** for health services, managed care is a blend of the financing and delivery of care. Comprehensive benefits are available to enrollees seeking care from a proscribed, limited provider network, with which the managed care organization (MCO) has established contractual relationships. Enrollees seeking care outside the approved network either receive reduced benefits or no coverage at all, depending on the plan's design. The MCO seeks to enter into provider contracts that allow for discounts from charges and which subject providers to certain parameters and standards for utilization and quality of care, set out by the payer. These plans may exercise considerable influence on the manner in which patients seek care as well as the manner in which care is provided to them.

Importantly, "demand" is driven not only by the introduction and utilization of new technologies and interventions, but by the demographic character of the population, as well. Shifts in the age, gender, race, prevalence of chronic illness, income, and education composition of the population exercise considerable impact on demand for – and use of – services. It is possible to exert influence over these factors through benefit design (limiting coverage of certain individuals or of certain services) and through the pricing of products.

Finally, states often employ strategies aimed at controlling the price and business of health insurance. These efforts are designed to assure that policies – particularly those sold in the small group and individual markets – meet certain minimum standards for access to coverage and care.

In this paper, we examine the history of these broad categories of cost containment initiatives, with an eye toward lessons learned.

CONTROLLING SUPPLY

Certificate of Need Regulation

One of the earliest regulatory strategies employed to promote cost containment by decreasing service duplication and investment in excess capacity is Certificate of Need (CON).²² Although cost containment has been the primary objective of CON, it also has been used, at least implicitly, as a strategy for encouraging hospitals to provide increased levels of indigent care.²³

First enacted by New York in 1964,²⁴ CON is a governmental program requiring certain types of health care providers to obtain state approval to make substantial capital investments in new equipment or facilities, to change bed complement (in hospitals) and to add or, sometimes discontinue, a patient service.²⁵ The National Health Planning Act, passed in 1974,²⁶ established the original federal statute relating to Certificate of Need; it was subsequently amended and expanded in 1979.²⁷ The law established a formal health planning process, including the SHPDAs (State Health Planning and Development Agencies) to attempt to exert some influence over the health care market, which was beginning to grow rapidly. This growth resulted in greater cost exposure for both the federal and state governments as they took their place among major payers following the enactment and implementation of the Medicare and Medicaid programs.

The National Health Planning Act contained a provision commonly known in health planning circles as “Section 1122.” That provision authorized states to establish CON programs and specified that capital investments that did not receive prior approval from the state health planning agency were not eligible for full reimbursement under the Medicare, Medicaid or federal Maternal and Child Health programs.²⁸ The provision set up minimum criteria for CON review: any project that would result in a change in hospital bed complement required CON review and approval, as did any project that would entail a change in the scope of services offered or that involved a capital investment of more than \$100,000. The 1979 amendments modified the minimum review criteria, applying it to the rental, lease or purchase of any diagnostic or therapeutic equipment costing

²² Campbell ES, Fournier GM. Indigent Hospital Care. *J Hlth Pol Policy Law*. Vol 18(4). Winter 1993.

²³ *id*

²⁴ McGinley PJ. Beyond Health Care Reform: Reconsidering Certificate of Need Laws in A Managed Competition System. *FL St Univ Law Rev*. 1995.

²⁵ Antlitz AM, Boyer E. Certificate of Need: A Physician Concern. *MD State Med J*. June 1979.

²⁶ Pub L No. 93-641

²⁷ Pub L No. 96-79

²⁸ Davis K, Anderson GF, Rowland D, Steinberg EP. *Health Care Cost Containment*. Johns Hopkins University Press. 1990. Baltimore and London.

\$150,000 or more, to be used in the treatment of hospital inpatients, regardless of where that equipment would be located (inpatient, outpatient or non-hospital settings). It also required prior notification to the health planning agency of investments exceeding the dollar threshold, even if the project would not be used in the care of inpatients.

The program reflects a perspective on the health care economy as representing an imperfect market – almost monopolistic in some respects – necessitating the intervention of government in order to improve its functionality and performance.²⁹ The lack of ability on the part of patients and payers to play a meaningful role in the performance of the health services market was prevalent until relatively recently, leaving the market power in the hands of the providers.

The CON regulatory approach is predicated on “Roemer’s Law” which implies that a built bed is a filled bed is a billed bed – alternatively, “if you build it, they will come.”³⁰ This economic view of the hospital market, in particular, sees hospital beds (and other resources) as generating their own demand. In order to compete effectively, hospitals invested in the newest technologies and developed new services (particularly high margin services such as heart centers) to attract physicians and patients.³¹ This imperative resulted in excess capacity – especially in areas that are hospital dense³² where they were least needed. Excess capacity must be supported financially, resulting in higher costs. The use of fee for service as the primary reimbursement strategy established an incentives for the provision of more services, especially if they had large profit margins. Under a cost-plus payment system, there was little risk related to the acquisition of new, expensive capital. At the same time, commercial payers simply passed the costs associated with capital expansion on to consumers through increased premiums.³³

A desire to do something to rein in the growth in health care expenditures stimulated the interest in regulation, although precise answers to this challenge were unknown. The federal government began to encourage state “experimentation” with different types of strategies to meet this challenge and states took up the call. As hospitals represented the major category of health care expense³⁴ and as technological expansion was recognized as a major driver

²⁹ Smith MD. Seeking Common Ground. *HSR*. Vol 29(1):33-34. January/February 1996.

³⁰ Sloan FA, Steinwald B. Effects of Regulation on Hospital Costs and Input Use. *J Law & Econ*. Vol 23(1):81-109. 1980.

³¹ This is a good example of non-price competition, which is characteristic of the health care market.

³² *supra* at 29

³³ *id*

³⁴ Strunk B, Ginsberg PB, Gabel JR. *Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000*. Center for Studying Health System Change. September 2001.

of inflation,³⁵ focusing on capital investment and constraint of growth in technology diffusion seemed to make sense.

By the mid 1970s, most states had passed their own CON laws and were participants in the federal §1122 initiative.³⁶ While complying with the minimum thresholds set out in federal law, each state employed its own version of CON, with differing thresholds (some more stringent than the federal limit); most states subjected both hospitals and nursing homes to regulatory oversight, but exempted physicians' offices.³⁷

The federal statutory authority expired in the mid 1980s, after which a number of states discontinued their own programs. Today, 38 states have CON programs, each reflecting the unique qualities of the states within which they operate. Many apply only to nursing facilities, some extend to physician offices and some only apply to the construction of new hospitals.³⁸

Impact

As noted above, the primary intent of Certificate of Need was to constrain cost increases by limiting investment in capital and avoiding the costly duplication of services. A secondary aim was the promotion of hospitals assuming higher levels of indigent care, the theory being to encourage the subsidization of such care with dollars that might otherwise be invested in excess capacity.

One of the earliest studies of the impact of CON was conducted by Salkever and Bice, using data for 1968-1972, examining the influence that state regulation efforts had on facilities. These investigators found that hospitals appear to have continued to invest in technology, while holding bed complement steady, resulting in the regulatory effort having no demonstrable impact on total investment or costs. Similarly, a 1986 study by Hellinger found no significant relationship between CON and decreased hospital investment.³⁹

Studies by Sloan and Steinwald using data from a six-year time series (1970-1975) also evaluated the impact of CON on the expansion of facilities and services, on hospital revenue and on utilization of services.^{40 41} These investigators came to a conclusion similar to their colleagues, finding that regulatory programs – including Certificate of Need – did not result in meaningful

³⁵ Okunad AA, Murthy VN. Technology as a 'major driver' of health care costs: a cointegration analysis of the Newhouse conjecture. *J Health Econ.* Vol 21(1):147-159. January 2002.

³⁶ *supra* at 30

³⁷ *id*

³⁸ Community Catalyst Website. www.communitycat.org, April 22, 2002.

³⁹ Hellinger FJ. Effect of Certificate of Need Legislation on Hospital Investment. *Inquiry.* Vol 13:187. 1976.

⁴⁰ *supra* at 30

⁴¹ Sloan FA. Regulation and the Rising Cost of Hospital Care. *The Review of Econ and Stat.* Vol LXIII(4):479-487. November 1981.

cost containment during the early part of the 1970s. They also documented a compensatory reaction on the part of hospitals that were anticipating the implementation of CON programs, with marked investment activity in the period immediately preceding program start-up, resulting in a spike in costs.

When the federal legislation expired in the mid-80s, several states chose to either repeal or sunset their CON programs. A study by Conover and Sloan found that the removal of CON regulation did not lead to a marked increase in health care expenditures, reinforcing the notion that this strategy failed to exercise any considerable influence over spending.⁴² The literature is silent, however, regarding what the current landscape might look like if CON had never been introduced. It is likely that this type of regulation exercised a chilling effect that discouraged the development of costly new projects.

The view of CON from a provider perspective varies depending upon which providers are consulted, and when. In a 1980 editorial, one physician characterizes CON as achieving nothing but a slow down in equipment acquisition, while serving as a full-employment act for health planners.⁴³ Others have viewed it as a call to arms for physicians to involve themselves more meaningfully in local health planning efforts.⁴⁴

Sloan and Steinwald point out that capital and facilities regulation tends to protect the providers already in the market, to the detriment of those trying to enter that marketplace. Like licensure, generally, that particular anti-competitive impact was likely to have been embraced by hospitals that struggled to maintain or gain position in a competitive market. In Maine, there was a tremendous struggle between one of the state's largest hospitals and community physicians when, in the early 1990s, a private group practice proposed purchasing an MRI – a plan that was met with displeasure by the hospital administration. This struggle for market position continues to this day. In the most recent legislative session, Maine lawmakers considered competing bills dealing with CON. The first, backed by the allopathic medical association, would have eliminated CON altogether.⁴⁵ This bill was strenuously opposed by the hospital association, which characterized the proposal as having “serious negative implications” for access to care and the promise of increased costs.⁴⁶ It is probably safe to

⁴² Conover CJ, Sloan FA. Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending? *J Hlth Pol Policy Law*. Vol 23(3):455-481. June 1998.

⁴³ Valaske MJ. Certificate of Need. *Pathologist*. Vol 34(2):77. February 1980.

⁴⁴ *supra* at 25

⁴⁵ Personal communication with Andrew MacLean, JD, General Counsel, Maine Medical Association, May 28, 2002.

⁴⁶ Maine Hospital Association website. http://www.themha.org/pages/new_pages/new2x.htm. May 28, 2002.

assume that similar scenarios play themselves out in other State Houses as well.⁴⁷

While the success of CON to constrain costs appears to have been less than optimal, it has been suggested that we have, perhaps, given it short shrift by not giving the redistributive effects of the program enough consideration.⁴⁸ Limits on capital investment may be viewed as key to the subsidization of indigent patient care, redirecting monies that would have been devoted to increased capacity to care formerly cross-subsidized by other payers. Campbell and Fournier suggest that CON has been used by regulators to implicitly pursue the aim of cross subsidization. They argue that regulators may use their authority to “trade” licenses or restrict competition in the health care market to create inducements for hospitals to provide increased levels of charity care, as restriction of entry into lucrative services is a necessary precondition to forcing higher levels of indigent care. Their study of Florida’s CON program between the years 1983 and 1989, found that limiting licensure of capital projects was essential to promoting the internal underwriting of indigent care, essentially serving as an alternative to legislated taxes to support such care.⁴⁹

More recently, there has been growing interest in the concept of regionalization of services and the creation of centers of excellence. A good deal of literature supports the hypothesis that there is a positive correlation between volume and favorable outcomes.⁵⁰ While patient education and payer policy can influence the migration of patients to high volume centers, limitations imposed by state governments via Certificate of Need can be quite useful in promoting regionalization of services.⁵¹ This strategy would help avoid duplication of services and promote better patient outcomes.

⁴⁷ A brief review of legislative bills for several other states’ most recent sessions supports this contention. Michigan, Missouri and Pennsylvania legislatures all had CON bills introduced and considered.

⁴⁸ *supra* at 22

⁴⁹ *id*

⁵⁰ See, for example, Birkmeyer JD, Siewers AE, Finlayson EVA, Stukel TA, Lucas FL, Batista I, Welch HG, Wennberg DE. Hospital Volume and Surgical Mortality in the United States. *NEJM*. Vol 346(15):1128-1137. April 11, 2002 and Begg CB, Riedel ER, Bach PB, Kattan MW, Schrag D, Warren JL, Scardino PT. Variations in Morbidity After Radical Prostatectomy. *NEJM*. Vol 346(15). April 11, 2002.

⁵¹ Epstein AM. Volume and Outcome – It Is Time to Move Ahead. *NEJM*. Vol 346(15):1161-1163. April 11, 2002.

Lessons Learned

There are a number of lessons for policymakers in the efforts undertaken by government in its attempts to curb investment in facilities and services:

- There is little data to support the notion that CON helps curb costs. While it does have a demonstrated impact on the number of patient beds, intensity of services appears to counteract any cost savings realized;
- There is a demonstrated correlation between CON and the availability of indigent care, redirecting funds from investments in capital to subsidization of care; and
- CON may be useful in promoting regionalization of services, with a concomitant improvement in patient outcomes for selected, high risk services.

The characteristics of CON programs vary from state to state, with no single program standing out as a model for others to adopt. It appears that the measure of influence particular interests have on the legislative and regulatory processes in each state are demonstrated in the reach and tenacity of the regulatory system.

CON was one of the earliest attempts at cost control and characterized an era when governmental intervention was viewed as a necessary element of any cost containment effort. It served as a precursor to rate regulation and, later, to the development of managed care systems, each strategy having similar goals. While some states allowed their CON programs to lapse (either by sunset or repeal) when the federal enabling legislation expired, many chose to continue the program as one device in a range of cost saving strategies, adopting rate regulation and encouraging the growth of HMOs at the same time.

CONTROLLING COSTS

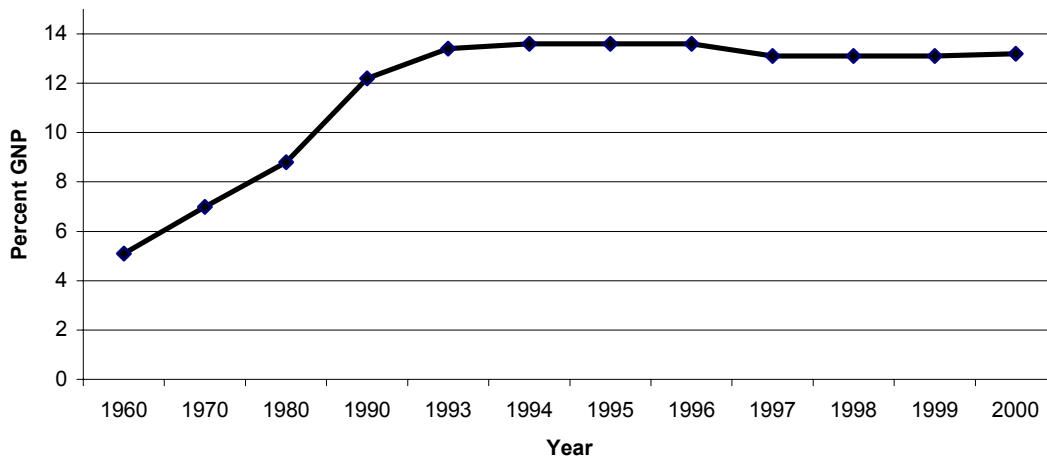
Hospital Rate Setting

Background

In the 1940s, the US witnessed the “birth of the blues” with the formation of the earliest private health insurance coverage – the forerunner of today’s Blue Cross and Blue Shield plans. This movement launched a trend in coverage structured on a fee for service model of reimbursement, providing risk protection both to enrollees and providers. Twenty years later, the New Societies era ushered in the Medicare and Medicaid programs, extending the benefits of health care coverage to some of our nation’s most vulnerable citizens and creating a new sensitivity to the cost of care for both the federal and state governments.

The introduction of Medicare and Medicaid was also marked by the initiation of several decades of rapid growth in health care expenditures, by government as well as private plans and individuals, which was, at least in part, fueled by the fee for service reimbursement orientation of the health insurance market.⁵²

National Health Expenditures as Percent of Gross National Product



Note: Data for chart taken from citation nos. 68 and 69

It has been argued that, because providers exercise considerable influence over the use of health services, fee for service systems tend to be inflationary as there is economic incentive to encourage utilization to maximize providers’ income.⁵³

⁵² *supra* at 28

⁵³ see, for example, RG Evans. *Strained Mercy: The Economics of Canadian Health Care*. Butterworths. 1984. Toronto.

Expenditures for health care rose from 5.1 percent of gross national product in 1960⁵⁴ to 13.2 percent in 2000.⁵⁵ (See chart above) While the majority of spending in 2000 was attributable to Medicare and Medicaid, private spending on health care grew at the same rate.⁵⁶ After a period of relatively stagnant spending increases observed since 1992, the rate of increase now appears to be gaining steam once again, raising the concerns of both the private and public sectors.

Inflation in the health care expenditures of the state and federal governments in their role as public payers stimulated a search for new ways to constrain costs and provide predictability in expense budgets, while safeguarding access to care. This was especially critical in the post-Vietnam era when the country faced substantial budget deficits attributable to the war effort. Nixon's Economic Stabilization Program (ESP), implemented in 1971, froze wages and prices throughout the economy, including the hospital industry (which accounted for the lion's share of health care expenditures); these restrictions would last until ESP's expiration in the spring of 1974.

ESP had the desired effect on hospital expenditures, reducing growth to somewhere between zero and three percent.⁵⁷ Once ESP was rolled back, though, Medicare expenditures for hospital care skyrocketed, increasing even faster than they had prior to the introduction of ESP. While this regulatory program was clearly unable to exert a sustainable influence on hospital costs, it does serve as an early rate setting model leading the way for many states in their own efforts to control health care expenditures.

In 1972, Congress amended the Social Security Act, allowing and encouraging states to experiment with new methods of cost containment. These amendments made provision for waivers for states pursuing cost controls via hospital rate setting. In 1983, further amendments encouraging cost containment innovation were enacted. These waivers allowed for the participation of federal programs in rate setting schemes, as long as increases in expenditures for hospital care did not exceed what would have been experienced without the regulatory system. This federal encouragement spurred a number of states to develop and institute rate setting as an answer to their rising costs⁵⁸ leading to, at one point just prior to 1980, regulatory efforts in almost thirty states.⁵⁹ However, interest and

⁵⁴ KR Levit, HC Lazenby, BR Braden, National Health Accounts Team. National Health Spending Trends in 1996. *Hlth Aff.* Vol 17(1):35-51. January/February 1998.

⁵⁵ K Levit, C Smith, C Cowan, H Lazenby, A Martin. Inflation Spurs Health Spending in 2000. *Hlth Aff.* Vol 21(1):172-181. January/February 2002.

⁵⁶ HCFA website: www.hcfa.gov/stats/NHE-OAct/hilites.htm. April 2002.

⁵⁷ *supra* at 28

⁵⁸ The first iteration of New Jersey's rate setting effort was actually implemented in 1969, well before the SSA amendments. That version of the program was not an all payer system and served as the model for the Medicare PPS.

⁵⁹ McDonough JE. Tracking the Demise of State Hospital Rate Setting. *Health Affairs.* Vol 16(1):142-149. 1997.

commitment to rate setting soon waned. Today, only Maryland's system remains intact. That system, though, has recently undergone substantial revision (discussed later).

There is variability in the form assumed by the enabling legislation in each regulatory state. Some states chose to lay out the parameters of the rate setting system in excruciating statutory detail, resulting in long, formulaic and complex laws and tightly constraining the flexibility and determinative action that regulatory staff took. Other legislatures chose to enact statutes that, instead, laid down the objectives and broad parameters for the regulatory system, leaving the development of the details of the system to agency staff and allowing them maximum flexibility. This latter model is credited as being a factor in the success of the long-standing Maryland system.⁶⁰

It is not entirely clear from the research what factors were instrumental in determining a state's decision to pursue rate setting. While worries about rising Medicaid budgets were certainly important determinants, other factors, such as high physician/population ratios, large Blue Cross and Medicaid market shares, high cost/admission and cost/capita, relatively high personal income levels and population density also appear to be related to regulatory adoption. The political environment in each state and state budget deficits also appear to have been influential.⁶¹

In the early 1970s, Congress actively encouraged states to employ rate setting as a cost containment device. At the same time, it acted to encourage the development of health maintenance organizations as another cost containment strategy. Because both of these strategies are related to the manner in which the market for health care services operates, it may seem counterintuitive that they would ever co-exist. However, the degree to which managed care was present in a given market does not seem to be related to the decision to adopt rate setting mechanisms. In fact, McDonough found the presence of independent practice associations and pre-paid group practices to be positively correlated with the operation of rate setting systems.⁶² He points out that this phenomenon does not imply that rate setting stimulates the development of managed care, only that the same environmental factors are conducive to both. High hospital costs, for example, are known to have motivated the desire to implement both rate setting policies as well as having stimulated the formation of managed care plans.

⁶⁰ *id*

⁶¹ McDonough JE. *The Decline of State-Based Hospital Rate Setting*. National Academy for State Health Policy. May 1995.

⁶² *id*

Characteristics

A wide range of variations of rate setting programs has been used over the years. There are four basic axes of each program, which can be used to describe its character:

- mandatory v. voluntary participation of providers;
- the regulatory or advisory nature of the rate setting body;
- the payers included under the regulatory scheme; and
- the unit that is regulated.

In 1980, most of the rate setting programs were voluntary in nature. Four state statutes mandated public disclosure of hospital budgets and charges, but carried no regulatory clout. Only eight programs were both mandatory and regulatory, that is, the law mandated compliance with rules and regulations established by a public rate setting body. Two other states implemented mandatory regulatory systems in the early 1980s, just as other states began to deregulate their markets.

The mandatory regulatory systems have proven to be of the greatest interest to policy makers, as it is these programs that have demonstrated the most significant influence on hospital costs. Four of these states – Maryland, New York, New Jersey and Massachusetts – obtained Medicare waivers, creating true “all payer” systems, where each payer in the market was required to participate in the regulatory program. Research has shown that the inclusion of all payers under the rate setting system enhances the program’s ability to control costs and is more conducive to the equitable funding of uncompensated care than less comprehensive regulatory efforts,^{63 64 65} as cost-shifting is minimized and payers bear their “fair share” of charity care and bad debt, as specified in the regulatory scheme.

Different rate setting programs regulate rates at different “levels” with some focused on per diem rates, per service rates or per case rates, others on global revenue caps and still others using a combination of these units. Prospective rate setting systems focus on output or the services produced, rather than inputs such as the cost of labor or other raw materials, as a strategy for encouraging cost conservation and the efficient use of resources. The selection of the unit regulated has consequences for the behaviors incented by the choice of approach.

⁶³ Rosko MD. A Comparison of Hospital Performance Under the Partial-Payer Medicare PPS and State All-Payer Rate Setting Systems. *Inquiry*. Vol 26:48-61. Spring 1989.

⁶⁴ *supra* at 61

⁶⁵ Hsiao WC, Sapolsky HM, Dunn DL, Weiner SL. Lessons of the New Jersey DRG Payment System. *Hlth Aff*. Vol 5(2):32-45. Summer 1996.

Many of the earliest programs started out regulating per diem rates or per service rates; these states saw drops in daily rates and ancillary charges. However, hospitals tended to respond to this type of constraint by generating an *increase* in the average length of stay along with a decline in ancillary service use (under the per diem strategy) or an increase in service intensity (in the case of per service regulation).⁶⁶ Some states, such as New York, attempted to control overall costs by imposing a budget cap over the per diem rates.⁶⁷

Between 1980 and 1987, hospitals in the area of Rochester, New York participated in the Hospital Experimental Program or HEP. This program established a broad range of financing and regulatory provisions, including what was essentially a global budget for the region and was intended to limit total hospital revenues.⁶⁸ An analysis of the project, conducted by Friedman and Wong, found that the initiative did indeed result in a restraint in the case mix adjusted cost per case. Capital investment and utilization of costly technologies were similarly constrained, without an impact on quality of care. The impact of the demonstration on hospital operating margins varied from one institution to the next.⁶⁹

Other states modified the unit regulated in an attempt to encourage more desirable behaviors. Per case regulation – first tested by New Jersey in the late 60s – predominated the second wave of regulatory efforts. Like Medicare’s PPS, this strategy centers on the development of prospective rates of reimbursement for case mix adjusted admissions. The payment allowance is set on a per admission basis and recognizes the costs associated with caring for more severely ill patients by setting higher payment rates for more complicated admissions. This type of payment allows for changes in case mix intensity or patient severity, but only recognizes the variable costs associated with changes in volume. Limits on charges are calculated using rates from a predetermined base year, and are made up of only those costs that are allowable under the particular regulatory scheme.

Medicare’s Prospective Payment System was spurred by the passage of the federal Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The program was to move Medicare to being a prudent purchaser of hospital services by shifting the program away from its historical cost-based reimbursement methodology to prospectively determined rates of payment based on diagnosis related groups. During the first year of PPS, hospitals realized substantial operating margins as a result of the system’s implementation. That windfall was quickly reversed, though, as the cost per discharge outstripped change in

⁶⁶ *supra* at 28

⁶⁷ *id*

⁶⁸ Friedman B, Wong HS. Impacts of Hospital Budget Limits in Rochester, New York. *Health Care Fin Rev.* Vol 16(4):201-219. Summer 1995.

⁶⁹ *id*

payment rates in PPS Years 2 and 3⁷⁰ generating a downward trend in the PPS margin that has continued.⁷¹ The rate of growth in federal Medicare spending has also remained on a downward trend, falling from an annual rate of 14.6% in 1998 to 5.6% in 2000.⁷²

The New Jersey DRG (diagnosis related groups)-based prospective payment system created an incentive for hospitals to curtail the length of inpatient stays, since payment was triggered by the admission and did not ordinarily vary by the length of a patient's stay. While average length of stay in New Jersey did fall following the implementation of the DRG payment system, hospitals offset that decline through increases in admission rates.⁷³ A similar phenomenon was observed in the earliest years of Maryland's rate setting program, as it was designed as a prospective "payment per case" system.⁷⁴

Trending allowable costs using a base year rate (as opposed to simply determining allowable costs anew each year) is intended to encourage cost conservation. However, there is risk in refusal to consider rebasing (i.e. updating the base rate) as an option at some point during the life of the system; such an inflexible stance may jeopardize the long term support for the regulatory system as the base year becomes more and more part of the distant past. The health system is changing rapidly; the goods and services that comprise a base rate from five years ago may simply not be representative of the goods and services used to produce health care today. Similarly, the willingness or latitude allowed by the system to grant exceptions to rate setting rules or make extraordinary adjustments is important.

The context within which hospitals operate has and continues to change at a stunning pace. It seems new technological advances become available on a daily basis. Hospitals are becoming increasingly complex organizationally, entangled in mergers, vertical integration and risk arrangements. The severity of illness observed in hospital inpatients has grown substantially as the population ages and as our ability to care for less severely ill patients in ambulatory settings increases. The ability to be flexible – as McDonough points out – is critical to regulators' capacity to ensure the system remains responsive and relevant to the changing environment.

Administrative procedures and the need for accountability can make it difficult for any regulatory system that relies on public rulemaking procedures to guide its actions to remain responsive to such a rapidly changing environment. That was

⁷⁰ Sheinhold SH. The First Three Years of PPS: Impact on Medicare Costs. *Hlth Aff.* Fall 1989:191-204.

⁷¹ Guterman S, Altman SH, Young DA. Hospitals' Financial Performance in the First Five Years of PPS. *Hlth Aff.* Spring 1990:125-134.

⁷² Heffler S, Smith S, Won G, Clemens MK, Keehan S, Zezza M. Health Spending Projections For 2001-2011: The Latest Outlook. *Hlth Aff.* Vol 21(2):207-218. March/April 2002.

⁷³ *supra* at 65

⁷⁴ *supra* at 63

certainly the case in Maine, where regulators strenuously resisted requests for exceptions and special adjustments as well as calls for rebasing from the industry, which contributed to a situation where the agency was constantly battling rate appeals and litigation, leading to the system's eventual political demise after a decade of cost containment.⁷⁵ Maryland also eventually found its system challenged by the profound changes in the market for hospital services in that state. As a result, the system has recently been substantially "renovated" and will include more frequent hospital rate reviews.⁷⁶

Outcomes/Impacts

The predominance of research on rate setting has focused on the several all payer systems originally enacted around 1980. There has also been considerable research regarding the utility and effectiveness of reimbursement mechanisms incorporating DRGs, although that question is beyond the scope of this paper. There is an entire body of literature devoted to the topic of diagnosis related groups, their design, intended consequences and actual impacts. This paper is focused on the use of DRGs as a unit of payment in hospital rate setting; discussion of the intricacies of the classification mechanism itself is left for others to address.

In fact, there is relatively little in the contemporary literature related to the evaluation of rate setting, reflecting the decline in interest in this cost containment strategy since the 80s. However, the published literature reflects broad-based agreement that rate setting was able to exercise considerable control over the cost/admission and over per capita hospital costs.^{77 78 79 80} For example, the New Jersey DRG rate setting system and the system in Maryland cut the average rate of increase in cost per case by almost 5%.⁸¹

In contrast, most investigators have found that rate setting has *not* constrained the rate of growth in health care costs per capita.^{82 83 84} This is attributable to the fact that these programs have largely failed to control rates of admission. Both

⁷⁵ Wihry DF, Fralich JT, Schneiter EJ. The political economy of rate regulation in Maine. *ME Pol Rev.* Vol 2(2):18-34. September 1993.

⁷⁶ *Achievement, Access and Accountability: A Guide to Hospital Rate Regulation in Maryland.* Maryland Hospital Association. January 2002.

⁷⁷ Schramm CJ, Renn SC, Biles B. Controlling Hospital Cost Inflation: New Perspectives on State Rate Setting. *Hlth Aff.* Vol 5(3):22-33. Fall 1986.

⁷⁸ *supra* at 59

⁷⁹ Biles B, Schramm CJ, Atkinson JG. Hospital Cost Inflation Under State Rate-Setting Programs. *NEJM.* Vol 303(12):664-668. September 18, 1980.

⁸⁰ *supra* at 63

⁸¹ *id*

⁸² Antel JJ, Ohsfeldt RL, Becker ER. State Regulation and Hospital Costs. *Rev Econ & Stats.* 1995.

⁸³ Finkler MD. State Rate Setting Revisited. *Hlth Aff.* Vol 6(4):82-89. Winter 1987.

⁸⁴ *supra* at 63

the Maryland and New Jersey systems were found to be associated with almost 4% annual rates of increase in the volume of admissions, offsetting savings generated on a cost/case level.

The degree to which substitution of unregulated outpatient services for regulated inpatient services has occurred as a direct market response to cost containment is debatable. Still, as noted earlier, we have witnessed a marked shift in delivery site off campus for many procedures previously offered only within the hospital walls. Costs (and expenditures) have followed these services into the community, resulting in lower inpatient expenses with no significant savings in total expenditures.

Some research has shown the early success of rate setting (in non-waiver states) began to erode as Medicare Prospective Payment System (PPS) went into full implementation.⁸⁵ This program stimulated increases in rates of admission, helping to offset gains made by the rate setting programs. It may be, however, that the introduction of PPS simply coincided with a period of rapid growth in managed care, which also exerted pressure on rate setting system; this phenomenon is discussed later.

Many critics of rate setting argued that this form of regulation would result in a marked degradation in the quality of care; this question, though, has yet to be answered. Hadley and Swartz concluded that savings from rate setting were primarily associated with increased efficiencies in production and/or degradation in the quality of care provided.⁸⁶ Hsiao and colleagues agree, finding that New Jersey hospitals responded to rate setting through belt tightening – letting plants age and going without full staff complements – rather than by influencing physicians to use resources more wisely. Similarly, Finkler argues that innovators will be loath to enter a market where prices are fixed.⁸⁷ Such reactions are argued to jeopardize the quality of care. In contrast, Smith *et al*, in a more recent study, failed to find any adverse relationship between rate regulation and patient or population mortality.⁸⁸

One of the most important policy features of rate setting systems – particularly all payer systems – is their potential to control cost shifting and “institutionalize” subsidization for indigent care.^{89 90 91 92 93} While many states cited cost control as

⁸⁵ *supra* at 77

⁸⁶ Hadley J, Swartz K. The Impacts on Hospital Costs between a980 and 1984 of HOsp;ital Rate Regulation, Competition, and Changes in Health Insurance Coverage. *Inquiry*. Vol26:35-47. Spring 1989.

⁸⁷ *supra* at 83

⁸⁸ Smith DW, McFall SL, Pine MB. State Rate Regulation and Inpatient Mortality Rates. *Inquiry*. Vol 30: 23-33. Spring 1993.

⁸⁹ *supra* at 59 and 61

⁹⁰ *supra* at 65

⁹¹ *supra* at 76

⁹² Sloan FA, Blumstein JF, Perrin JM, ed. *Uncompensated Hospital Care: Rights and Responsibilities*. Johns Hopkins University Press. Baltimore/London. 1986.

their primary goal for their rate setting programs, access to care for the medically indigent was often mentioned as a motivating factor for passage of such a program. When rate regulation involves the actual approval of a gross revenue limit, limits per diem or limits per unit of service, the regulatory agency is able to build in an allowance for expected charity care and bad debt. In states where negotiated discounting is prohibited, this allowance may be more equitably allocated over all payers covered under the rate setting system. Rather than pushing the responsibility for shortfalls attributable to indigent care to payers with less capacity to negotiate a substantial discount, a comprehensive rate setting system is able to redistribute this burden, assuring payers share this cost-shift proportionately.

The evidence regarding the impact rate setting has on hospital profitability and financial condition is mixed. Arguably, a payment system should allow efficient providers to remain viable. However, if rates are set too high, the system will fail to realize its cost containment goals. If they are set too low, hospital financial positions may be compromised.

In a study by Hsaio and colleagues, data is presented documenting that between 1997 and 1985, hospitals in Maryland and New Jersey tended to have operating margins that were somewhat below the national median, suggesting that the rate setting systems in those states reduced the hospitals' "bottom line."⁹⁴ The same study points out that little evidence can be found to differentiate the financial impact of all payer systems versus partial payer systems.⁹⁵ In his 1982 paper, Mitchell finds that rate setting exercised harmful effects on the profitability of the hospital sector,⁹⁶ an observation echoed by the Maryland Hospital Association in its response to the Mitchell article.⁹⁷

The Maryland Rate Setting Commission documents the degradation in the financial condition of hospitals under the payment system in a January 2002 report. At the end of the system's second decade, serious concerns began to be raised regarding hospital financial positions, spurring an in-depth study and the development and implementation of corrective action. These changes resulted in operating margins at Maryland hospitals roughly equaling those seen nationally. Moreover, the average age of plant, which had been increasing over years (presumably due to the rate setting system's less than desirable treatment of capital allowances), declined markedly toward the national norm.⁹⁸ This trend has not lasted, however, and it appears that Maryland hospitals are again experiencing problems related to narrow operating margins, low liquidity, and high debt ratios. A redesign of the Maryland system which will address these

⁹³ *supra* at 28

⁹⁴ *supra* at 65

⁹⁵ *id*

⁹⁶ Mitchell SA. Issues, Evidence, and the Policymaker's Dilemma. *Hlth Aff.* Vol.1:84-98. Summer 1982.

⁹⁷ Davidson RJ. ReViews: A State Hospital Association. *Hlth Aff.* Vol. 1:12-128. Summer 1982.

⁹⁸ *supra* at 76

issues was implemented in 2000, and is currently in the midst of a three-year pilot period.⁹⁹

Interestingly, others dismiss the claim that rate setting has a deleterious impact on hospitals' financial conditions. Schramm, *et al*, found the opposite, presenting data to support the observation that the financial position of hospitals in regulated states actually improved over the study period.¹⁰⁰ Similarly, Sloan could find no strong evidence that mandatory rate setting programs eroded hospital operating margins.¹⁰¹ Differences in findings may be attributable, in part, to the statistical models used by different investigators, differing temporal boundaries of the studies and differing data sets.

Rate setting and managed care

Just as critics used quality as a touchstone for arguing against the use of rate setting, so, too, did they argue that rate regulation and managed care would be incompatible. This simply has not proven to be the case. Most of the early adopter states had, at the time, greater than average HMO penetration.¹⁰² The same factors driving states to contain costs through rate setting (rapidly rising health care and hospital costs) also predisposed markets to the development of managed care. And the same federal legislation that encouraged states to experiment with rate setting also encouraged the development of HMOs.

In all fairness, however, the period when rate setting was in vogue was early in the development of HMOs, which enjoyed relatively small market shares. Because managed care claimed such a small proportion of the market, the two cost containment strategies did not get in each other's way. However, in the 1990s, when managed care experienced such rapid growth, the once benign co-existence came to loggerheads.¹⁰³ As the HMOs grew larger and more sophisticated, they became a force to be reckoned with. Believing they would be able to extract better "deals" than what a regulatory agency could provide them, these plans began to demand discounts from charges, when those rate setting systems typically only allowed limited differentials for Blue Cross and Medicaid payers. The political clout wielded by managed care plans was impressive, sweeping along the business community and other key stakeholders who once were supportive of rate regulation into a clamorous call for competition.

Only Maryland was able to weather this storm, a feat attributable, once again, to the substantial flexibility allowed by that system, and to the fact that its Medicare

⁹⁹ *id*

¹⁰⁰ *supra* at 77

¹⁰¹ *supra* at 41

¹⁰² *supra* at 59

¹⁰³ In fact, rate setting may be argued to have assisted in nurturing the growth of small managed care plans, assuring that they were not subject to undue cost shifting of bad debt and uncompensated care at a time when those plans carried little negotiating clout with hospitals.

waiver has been maintained over the years.¹⁰⁴ ¹⁰⁵ Regulators there were able to accommodate experimentation with capitation within the framework of rate setting and managed care continued to flourish in Maryland while rate setting was sustained.¹⁰⁶ In other states, a preference for free markets resulted in a roll back of all payer systems to allow for negotiated discounting, the first step toward deregulation.

As McDonough points out in his 1997 paper, it is interesting to note that rate setting (that has moved from per diem to per case payment) and capitation are both forms of prospective payment. Rather than being ideological opposites, they are instead, merely two points on a spectrum of payment mechanisms. The shift from one to the other represents an *evolution* in payment methodology, as opposed to a *revolution*. Rate setting may be viewed as a bridge to the development of capitated systems, constraining costs until managed care could take hold.

Issues

In addition to the advent and growth of managed care, regulatory failure contributed to the decline of rate setting. By its very nature, economic regulation is extremely complex, generating a myriad of rules, regulations and policies that are almost incomprehensible, even to regulatory and hospital staffs;¹⁰⁷ one writer describes the Massachusetts rate setting code as “Sanskrit.”¹⁰⁸ This degree of complexity makes it difficult to explain the system to the public (including legislators) and fosters confusion and suspicion, which, in turn, creates vulnerability in the system.

Cooptation is also a danger inherent in these systems, as it is in any regulatory program. Regulatory capture is characterized by a system that works to further the interests of the regulated industry over that of consumers, with the regulatory agency adopting the objectives of the industry as its own. Support for the implementation of state rate setting reflected the self-interest of key stakeholders such as state and national hospital associations, insurers, business and labor, as well as state government.¹⁰⁹ They were all searching for a way to respond to rapidly rising costs. Hospitals were interested in averting the imposition of federal cost controls; insurers were interested in protecting themselves against the growing problem of cost shifting. Payers and purchasers were searching for ways to stem the rising tide of hospital expenditures – Medicaid and otherwise. The

¹⁰⁴ *supra* at 59

¹⁰⁵ *supra* at 76

¹⁰⁶ It is also noteworthy that Maryland was the only state to have maintained its Medicare waiver, which represented a net influx of revenues to the state’s hospitals of \$200-\$300 million annually.

¹⁰⁷ *supra* at 75

¹⁰⁸ *supra* at 59

¹⁰⁹ *id*

political influence of these parties obviously varied from state to state as did their ability to craft the system to their own advantage.

The statutory language and the resulting regulations shaping the individual rate setting systems reflected the relative power of these interest groups. In some instances, the systems served to protect the relatively inefficient hospital, in others payer differentials were prohibited. As managed care grew and exhibited substantial cost savings in non-regulated states, key stakeholders became enamored of the capitation strategy and began to abandon support for rate setting in favor of this “new” approach.

Most of the rate setting systems were implemented in a political environment that might be characterized as liberal.¹¹⁰ Most deregulation coincided with a shift in control of State Houses and Governor’s mansions to a more conservative orientation¹¹¹ and a marked pro-competition attitude. It seems likely that what happened was that stakeholders, anxious to give managed care a run for its money, used the dramatic shifts in governance as an opportunity to push their revised agenda. The new governments – with more conservative stances on state regulation – took up the issue, making deregulation a cause celebre.¹¹²

Only Maryland departed from this course. According to McDonough, long-term Democratic control of state government sets Maryland apart from states that deregulated.¹¹³ In addition, that state can also quantify and document sustained cost containment successes, holding the rate of increase in hospital cost/admission well below the national average for many, many years.

Lessons Learned

As discussed above, the primary objective of rate setting is cost containment. Success in that arena appears mixed (as cited earlier) and varies with the comprehensiveness of the system. The subsidization of indigent care is also a major goal of rate setting. In this regard, rate setting – particularly all payer systems – seem to have realized relative success.

There are certain factors critical to the success of rate setting systems:

- statutory flexibility appears to be vital to the long term viability of any regulatory system, which must be able to adapt to a rapidly changing environment;

¹¹⁰ *supra* at 63

¹¹¹ *supra* at 59

¹¹² *id*

¹¹³ *id*

- rate setting systems must have the authority to limit payer discounts in order to avoid an erosion of the system (and hospital financial viability) created by lopsided negotiating power of a few influential payers;
- there must be solid political support for the system; and
- the inclusion of all payers – including Medicare – under the rate setting scheme provides great strength to the system by minimizing cost shifting and maximizing equity among payers.

The Maryland program is the best example of a successful system, as demonstrated by the fact that it is still functioning after three decades. At the outset of the regulatory program, Maryland had the highest hospital costs in the nation; at the close of the last decade those costs were at the national average.¹¹⁴

The success of rate setting must be evaluated in light of its goals. Most systems were implemented to control the rate of increase in hospital care; quite simply, they achieved that goal. It was perhaps the short-sightedness of policymakers that early cost containment efforts were not focused on health care expenditures, generally, but that was not the explicit focus or purpose of enacted rate setting statutes. Moreover, rate setting was intended to accomplish a more equitable distribution of the cost of caring for the medically indigent, relieving individual hospitals from extraordinary bad debt and charity care burdens by spreading subsidization of such costs equally across all other payers. This objective was also realized, and was one of the most important contributions of rate setting, enhancing access to hospital care for those states' most vulnerable citizens.¹¹⁵ While cost containment might be achieved through the use of other strategies, such as capitation and managed care, payer equity is unique to the rate setting approach.

¹¹⁴ Maryland Health Services Cost Review Commission. Report to the Governor for Fiscal Year 2001.

¹¹⁵ *id*

CONTROLLING DEMAND

Managed Care

Background

Although we tend to think of managed care as a relatively new phenomenon, prepaid care actually dates back to the late 1920s. The forerunners of the modern HMO were born out of a farmers' cooperative in Oklahoma and in LA, where the Ross-Loos Medical Group provided prepaid care to the employees of LA County's Water and Power, and their dependents.¹¹⁶ Like today, the initial growth of prepaid care was stimulated by business and community groups searching for ways to increase the availability of affordable health care.

In the early 1930s, a single physician – a surgeon practicing in southern California – began a prepaid health plan for workers building the Los Angeles aqueduct. Dr. Garfield was paid 10 cents/day to provide care to construction workers. This arrangement captured the attention of Henry Kaiser, a California industrialist who was looking for ways to provide health care for workers (and their dependents) involved in the construction of the Grand Coulee Dam. In 1938, Kaiser recruited Garfield to develop a prepaid group practice at a hospital located in close proximity to the construction site. The dam was nearing completion when WWII broke out, bringing an influx of workers to Kaiser's shipyards and presenting Kaiser with the challenge of providing affordable health services to 30,000 employees. Once again, Kaiser persuaded Garfield to take up the challenge and the prepaid group practice came to San Francisco. At the height of the war, the new plan served as many as 200,000 members.

In 1945, the Kaiser health plans were open to community enrollment and, in the early 50s, enrollment reached a quarter million members. In 1955, the corporate entity known as Kaiser Permanente was formed out of the early health plans – plans that exist to this day. Kaiser Permanente now operates managed care plans across the country that, in 1990, boasted 6.5 million members.¹¹⁷

Another of the earliest managed care plans, Group Health Cooperative of Puget Sound was launched in 1947. Today, GHCPs is the largest consumer-governed health care organization in this nation and is still operated as a cooperative. Based in Seattle, GHCPs cares for 10% of Washington residents along with residents of northern Idaho, and has a membership of over 600,000.¹¹⁸

¹¹⁶ HAP Website. www.hapcorp.org, April 2002.

¹¹⁷ Kaiser Permanente Website. www.kaiserpermanente.org. April 2002.

¹¹⁸ www.ghc.org. April 2002.

As health care costs escalated in the 1960s, calls for cost containment grew. The Nixon administration promoted the growth of prepaid health plans as part of the answer to the growing cost crisis, coining the term “health maintenance organization.” In 1973, on the heels of the amendments to the National Health Planning Act allowing rate setting (which occurred in 1972), Congress enacted the Health Maintenance Act. This statute encouraged the development of HMOs by making federal funds available for grants and loans for the establishment of new health plans and by requiring employers who offer health insurance to offer an HMO option, when available. By the end of 1978, there were more than 200 HMOs operating in over 37 states.¹¹⁹ In 1981, Congress once again demonstrated its interest in managed care with the passage of OBRA, where it authorized states to demonstrate new models of financing and delivering care to Medicaid recipients. This authorization included the establishment of the “freedom of choice” waiver, which permitted states to restrict recipients’ access to health care providers for the first time. The bill also relaxed the contracting requirements facing states wishing to enroll beneficiaries in HMOs.¹²⁰

The basic premise of managed care is that effective health care services may be provided with greater efficiency (including cost efficiency) if providers are encouraged to make wise and careful treatment decisions. In managed care systems, the payer attempts to influence the service provider using any variety of strategies, including financial incentives, prior authorization requirements for certain procedures or services, the establishment of “best practices” and treatment protocols.¹²¹ Some of the earliest managed care models completely blended the payment and provider mechanisms, with payers using staff physicians (and sometimes their own hospitals) to deliver care to members. Others put the physician at financial risk for service utilization above actuarially expected levels, creating strong incentives for careful treatment decisions.

Now the line between these varieties of managed care organizations is blurring. Commercial insurers now offer products that look similar to HMO plans, with preferred provider networks and physician financial incentives to constrain costs. HMOs have spun-off point of service products, that relax member restriction to a particular set of physicians. Still, the objective remains the same: lower costs and lower rates of growth in costs – and, therefore, in premiums.¹²²

The growth of managed care has been remarkable – it has even been characterized as a “revolution” by the industry.¹²³ During the 1980s, as employers looked for strategies to help them budget for and contain the cost of health benefits, the number of HMOs more than doubled and enrollment

¹¹⁹ *supra* at 116

¹²⁰ Previously, states had been only allowed to enroll recipients in federally qualified prepaid health plans with less than 50% Medicaid or Medicare enrollment.

¹²¹ Claxton G. *How Private Health Insurance Works: A Primer*. Kaiser Family Foundation. April 2002.

¹²² *id*

¹²³ Ignani K. Covering a Breaking Revolution. *Hlth Aff.* Vol 17(1):26-34. January/February 1998.

quadrupled.¹²⁴ Enrollment continued to expand during the early 90s, reaching an average annual growth rate of almost 7%; approximately 78 million Americans were enrolled in managed care plans by 1998.¹²⁵ In 1988, only 18% of employees in mid- to large-sized companies were enrolled in HMOs. Ten years later, that figure had grown to over 50%.¹²⁶ In 1995, nearly 70% of all covered lives were in managed care products; that figure is projected to increase to more than 90% by 2007.¹²⁷

The trend toward managed care has also been felt in the public sector, as states searched for answers to the challenge of rising costs. In 1983, 750,000 Medicaid recipients were enrolled in managed care programs.¹²⁸ That number grew to 4.8 million by 1993¹²⁹ and to 18.8 million by 2000.¹³⁰ Managed care has been the dominant delivery system in Medicaid since 1998 serving those with complex needs as well as families.¹³¹ Fifty-five percent of Medicaid beneficiaries were enrolled in one of more managed care programs in 2000.¹³² As of the end of 2001, 31 states and the District of Columbia enrolled proscribed categories of Medicaid beneficiaries in limited areas of their jurisdictions into managed care plans under the authority of federal 1915(b) waivers (waiving comparability and statewide application). Nineteen states had active Section 1115 waivers, allowing for the implementation of mandatory, statewide managed care enrollment.¹³³ The share of the Medicaid population in managed care rose from less than 10% in 1991 to more than 50% by late 1998, reflecting states' desires to control costs and improve continuity of care through managed care.¹³⁴

Growth of managed care continued into the mid-1990s, not flattening out in the commercial sector until 1996; Medicaid enrollments began to stabilize in 1998 although it continued to grow slowly through 2000.¹³⁵ The slow-down in Medicaid managed care is interesting in light of the fact that in 1997, Congress enacted the Balanced Budget Act, which allowed states to require enrollment in managed

¹²⁴ *id*

¹²⁵ *Health and Health Care 2010: The Forecast, The Challenge*. The Institute for the Future/ IOM. Jossey-Bass. January 2000. San Francisco.

¹²⁶ Reschovsky JD, Kemper P. Do HMOs Make a Difference? *Inquiry*. Vol 36: 374-377. Winter 1999/2000.

¹²⁷ *id*

¹²⁸ Brach C, Scallet L. Trends. A E Casey Website. ww.aecf.org/publications/challeng/trends.htm. May 2002.

¹²⁹ *id*

¹³⁰ Medicaid and Managed Care. Kaiser Commission on Medicaid and the Uninsured Fact Sheet. December 2001.

¹³¹ Kaye N. *Medicaid Managed Care: A Guide for States, 5th Ed*. National Academy for State Health Policy. 2001. Portland, ME.

¹³² *id*

¹³³ *id*

¹³⁴ Long SK, Coughlin TA. Impacts of Medicaid Managed Care on Children. *HSR*. Vol 36(1)Part I:7-23. April 2001.

¹³⁵ *supra* at 131

care without special waivers¹³⁶ and which lifted a previous federal ban on Medicaid-only managed care plans. The increased flexibility granted to states has not yet stimulated any marked upswing in managed care enrollment. This is likely due, in part, to a trend among managed care companies to exit the Medicaid market; by 1998, there were far more companies leaving that market than entering it.¹³⁷ This trend was probably related to the fact that Medicaid reimbursement rates have historically been below commercial reimbursement rates. Federal waivers require state managed care systems to be budget neutral, thereby forcing capitation rates to be lower than those offered by commercial products, making provider participation difficult to sustain.

The American love affair with managed care was fueled by a period of increases in health care costs that, in turn, generated considerable increases in health care premiums. Managed care plans were typically priced lower than traditional indemnity products, and consumers/payers consistently opted for lower premiums over free choice of providers, migrating away from indemnity plans. In Minnesota, researchers documented an 8.6% decline in indemnity market share for every 1% increase in the premium differential between HMO and indemnity products.¹³⁸ Fearing they would be left out in the cold, providers joined managed care networks so they could care for enrollees.

As managed care plans gained market share, they used their new-found power to leverage deeper provider discounts, trim provider networks and transfer risk to providers such as hospitals and physicians.¹³⁹ Despite the curtailment in access, consumers still flocked to the plans,^{140 141} ever increasing the managed care market position. This triggered rounds of consolidation by both providers and – as a reaction – health plans, to try to reach some form of market stasis. Vertical and horizontal integration became *de rigueur*, and reimbursement mechanisms have grown increasingly complex. Undoubtedly, we have not seen the end of this transformation, yet the precise future of managed care remains unknown.

Characteristics

There are many different configurations of managed care, each utilizing different payment mechanisms. These range from staff model HMOs, to prepaid group practices, independent practice associations and loosely affiliated networks of providers associated with a managed care insurer. There are global capitation

¹³⁶ The exception being the case of children with special needs, dual eligibles and Native Americans.

¹³⁷ *supra* at 134

¹³⁸ Zwanziger J, Melnick GA. Can Managed Care Plans Control Health Care Costs? *Hlth Aff.* Vol 15(2):186-199. Summer 1996.

¹³⁹ *id*

¹⁴⁰ *id*

¹⁴¹ This refers *consumer* choice of managed care plans over more traditional policies as opposed to a choice by purchasers or employers to offer only managed care plans.

models, where providers are at risk for all health care services, partial capitation models, discounted fee for service arrangements, and primary care case management, with many providers bearing essentially no risk at all. By the end of the 1990s, payment arrangements in managed care plans broke down into four major categories as follows:

- 10% of enrollees were in plans that used global capitation;
- 17% were in plans capitating physician services only;
- 29% of enrollees were in discounted fee for service plans that used withholds and risk pools; and
- 44% were in plans that employed only discounted fee for service arrangements.¹⁴²

Regardless of the particular shape or form of managed care, plans use provider arrangements, financial incentives and administrative tools to reduce the use of unnecessary services and costs while, simultaneously, striving to improve the quality of care. While managed care products generally lower financial barriers for consumers (e.g. by employing modest copayments as opposed to substantial deductibles and, often, through lower premiums), they often use financial incentives – such as capitation – with providers to encourage a more efficient use of services. This particular attribute is often viewed as setting up a disincentive for providers to deliver needed patient care.

Through the use of broad benefit plan designs, managed care plans tend to provide enrollees coverage for primary and preventive services to a greater degree than traditional indemnity products do.¹⁴³ These plans maintain relationships with physicians who agree to abide by prescribed participation principles. Enrollee access to care is ordinarily gained through one of these participating providers and specialty care is usually obtained via referral from a patient's primary care physician – the “gatekeeper”, which is, in turn, sometimes subjected to prior authorization by the managed care company. Plans try to encourage the use of less expensive care as a substitute for more costly care and to rein in the use of services deemed to have only marginal utility.

Clearly there are trade-offs for consumers involved in choosing between a managed care plan and an indemnity product. On the one hand, the managed care products offer a broader range of benefits at a potentially lower out of pocket cost to the patient. On the other, managed care plans typically restrict access to services. As noted earlier in this paper, consumers' sensitivity to price is high, thus making the lower financial barriers characteristic of HMOs or other managed care plans relatively more attractive than non-HMO products. In fact, privately insured (nonelderly) HMO enrollees generally have lower incomes than that of non-HMO enrollees, increasing their price sensitivity; many more HMO

¹⁴² *id*

¹⁴³ Tu HA, Kemper P, Wong HJ. Do HMOs Make a Difference? Use of Health Services. *Inquiry*. Vol 36:400-410. Winter 1999/2000.

enrollees report a willingness to trade choice for cost savings and prefer policies with lower out of pocket costs.¹⁴⁴ They are also more likely than their non-HMO counterparts to be single, younger and part of a minority group.¹⁴⁵

Impact

There are several major axes along which we might evaluate the impact of managed care. They are: access to services, service utilization and cost, quality of service provided, and consumer satisfaction.

There is a well-developed literature on the issue of the impact of managed care on enrollees.¹⁴⁶ However, many articles report on studies done with limited data sets and findings are not suitable for generalization. The Community Tracking Study Household Survey, conducted in 1996-1997, avoids that problem by taking a large, nationwide sample.¹⁴⁷ These survey data were used by investigators at the Center for Studying Health System Change to assess the impact of HMO enrollment on access, service utilization and consumer assessment. The investigators adjusted the data for differences in health status, income, enrollee demographic characteristics, enrollee preferences and available insurance options.¹⁴⁸ They also adjusted the data for differences in each of the local health care markets from which survey data were obtained. These adjustments allowed the survey data to be aggregated and used for purposes of making generalized statements regarding HMO versus non-HMO experiences. Prior to this work, observations could be made at the plan level, but could not be generalized.

Access to Care

As pointed out by Reschovsky, despite general fears that HMOs may leave patients – particularly those with chronic health conditions – out in the cold, without access to needed care, there is very little empirical evidence that might justify those fears.¹⁴⁹ The Community Health Tracking studies found the same to be true. HMO enrollees are less likely to face financial barriers to care, such as high out of pocket costs; non-HMO enrollees were more likely to report that they did not receive needed care because of financial barriers.¹⁵⁰ HMO enrollees are significantly more likely to report that they have a usual source of care, but are significantly more likely to report experiencing a delay in receiving what they perceive to be necessary care or having unmet needs due to restrictions in access to providers.¹⁵¹ HMO enrollees are also more likely to report

¹⁴⁴ Kemper P, Reschovsky JD, Tu HT. Do HMOs Make a Difference? Summary and Implications. *Inquiry*. Vol 36:419-425. Winter 1999/2000.

¹⁴⁵ *id*

¹⁴⁶ Reschovsky JD. Do HMOs Make a Difference? Access to Health Care. *Inquiry*. Vol 36:390-399. Winter 1999/2000.

¹⁴⁷ Center for Studying Health System Change Website. <http://www.hschange.com>, April 2002.

¹⁴⁸ These data relate exclusively to privately insured persons

¹⁴⁹ *supra* at 146

¹⁵⁰ *id*

¹⁵¹ *id*

experiencing unmet or delayed health care needs as a result of convenience or organizational factors such as waiting time for appointments, or office hours. However, in all cases where there are statistically significant differences between HMO and non-HMO enrollees, they are relatively modest differences. Long and Coughlin report similar findings with respect to the experience of children covered by Medicaid who are enrolled in managed care plans.¹⁵²

Utilization of Services

Using the Community Tracking Study data, Tu and colleagues examined the impact exerted by HMOs on the use of services.¹⁵³ They found that HMO enrollees exhibit a higher use of ambulatory services, generally, than do non-HMO enrollees; this difference is significant, but modest. HMO enrollees demonstrate a greater likelihood of making any ambulatory visit and those making at least one visit tend to make more visits than their counterparts outside the HMO. This same trend is documented in the use of physician visits, particularly, although those data reflect a preference for – or greater use of – primary care physicians as opposed to specialists. The difference in receipt of mental health services between HMO and non-HMO enrollees is not statistically significant.

HMO enrollees are more likely to receive preventive services such as mammography and flu shots, but there is little evidence to support the hypothesis that HMOs markedly reduce the use of hospital care or surgery. Further, there is no evidence that HMOs substitute outpatient surgery for inpatient surgery.¹⁵⁴ Miller and Luft found that HMOs had lower use of expensive procedures, tests and treatments that could be substituted for by lower cost alternatives;¹⁵⁵ in a more recent literature review, these same investigators failed to turn up any documentation of differences in resource utilization.¹⁵⁶

Long and Coughlin report finding few differences between Medicaid children enrolled and not enrolled in managed care with respect to utilization.¹⁵⁷ Rowland and colleagues note that the impact on the use of physician services by Medicaid enrollees in managed care programs is mixed, with primary care case management participants being more likely than HMO participants to have increased numbers of office visits.¹⁵⁸ Their study also found a decline in the non-urgent use of emergency department services and a lower use of specialty

¹⁵² *supra* at 134

¹⁵³ Tu HT, Kemper P, Wong HJ. Do HMOs Make a Difference? Use of Health Services. *Inquiry*. Vol 36:400-410. Winter 1999/2000.

¹⁵⁴ *id*

¹⁵⁵ Miller RH, Luft HS. Managed Care Plan Performance Since 1980: A Literature Analysis. *JAMA*. Vol 271(19):1512-1519. May 18, 1994.

¹⁵⁶ Miller RH, Luft HS. Does Managed Care Lead to Better or Worse Quality of Care? *Hlth Aff*. Vol. 16(5):7-25. September/October 1997.

¹⁵⁷ *supra* at 107

¹⁵⁸ Rowland D, Rosenbaum S, Simon L, Chait E. *Medicaid and Managed Care: Lessons from the Literature*. Kaiser Commission on the Future of Medicaid. March 1995. Menlo Park, CA.

referrals, than demonstrated in the fee for service Medicaid population. Finally, Rowland, *et al*, note that managed care does not appear to impact the use of preventive services by Medicaid beneficiaries, with both fee for service and managed care populations being low utilizers of such care.¹⁵⁹

Quality

Undoubtedly, we have all read and heard horror stories about the quality of care provided to patients in managed care plans. The use of provider financial incentives such as capitation – which puts providers at risk for the total health care costs of a given enrollee – does have the potential for promoting undertreatment in favor of maximizing a provider’s revenue. However, the empirical data do not support the popularized notion.

Long and Coughlin found that Medicaid children enrolled in managed care plans did not receive substandard care.¹⁶⁰ Rowland and colleagues found little difference between the quality of care provided under Medicaid managed care to that delivered to the Medicaid fee for service population.¹⁶¹ In a 1997 meta-analysis, Miller and Luft found the published studies split on this issue, with half of the papers citing improvements in quality and outcomes, while the other half cited degradation in care. They note that the public’s fears that managed care will always lead to worse care are unfounded. By the same token, they note that hopes for quality improvement under managed care are unsupported, as well.¹⁶² This contention is supported by the Committee on Quality Health Care in America, which prepared the IOM’s report entitled *Crossing the Quality Chasm*. That report notes that the published literature neither supports nor refutes the argument that managed care promotes poor quality care.¹⁶³

The one instance where a difference in quality of care was documented is noted in Miller and Luft’s research. The Medical Outcomes Study found that chronically ill elderly enrollees enrolled in HMOs experienced better quality of care for mental health.¹⁶⁴

Consumer Satisfaction

Community Health Tracking data demonstrate the HMO enrollees report less favorable “reviews” of their health care plan than do non-enrollees, the only exception being the level of trust they have in their physician to provide only necessary services.¹⁶⁵ Although statistically significant, the differences are modest. Importantly, most enrollees – regardless of plan type – give generally high satisfaction ratings to their plans; only a small percentage of HMO enrollees

¹⁵⁹ *id*

¹⁶⁰ *id*

¹⁶¹ *supra* at 158

¹⁶² *supra* at 156

¹⁶³ Committee on Quality Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Institute of Medicine. 2001.

¹⁶⁴ *supra* at 156

¹⁶⁵ Lake T. Do HMOs Make a Difference? Consumers Assessments of Health Care. *Inquiry*. Vol. 36:411-418. Winter 1999/2000.

give unfavorable reviews. In their 1994 meta-analysis, Miller and Luft found that HMO enrollees were generally less satisfied with the non-financial aspects of their coverage, but were generally more satisfied with the financial aspects of their plan.

Long and Coughlin report little difference in satisfaction between HMO enrollment and non-HMO enrollment for Medicaid children. Fraser and colleagues report a relationship between having a choice of plans and satisfaction with managed care enrollment among Medicaid beneficiaries.¹⁶⁶

Cost

The question of managed care's impact on cost is answered differently depending upon whom you ask the question and how you ask it. In a 1996 paper, Zwanziger and Melnick describe the evolution of managed care in California and Minnesota, which led the nation in the deployment of this type of health care financing and delivery. These authors argue that the price competition between plans and providers stimulated by the dissemination of managed care into a market motivates both parties to control costs and present data that show that as HMO penetration in an area increases, insurance premiums tend to fall. In the work reviewed by Zwanziger and Melnick, there was a demonstrated reduction in hospital costs in California markets characterized by a high managed care presence; these reductions were of the same magnitude as those achieved by rate regulation in New York and New Jersey. They concede, however, that they are not able to clearly attribute these declines to lower costs. Still, they argue that managed care has succeeded in reducing the rate of growth in health care costs, demonstrating that the market can successfully assume a pseudo-regulatory role.¹⁶⁷

In their 1994 literature review, Miller and Luft were able to identify relatively scanty evidence regarding the impact of managed care on costs. They found no significant differences in charges per admission or in ambulatory expenditures per enrollee. They uncovered some data indicating that managed care enrollees did experience somewhat lower total expenditures per capita.¹⁶⁸

Sullivan notes in a recent article that the boast of efficiency attributed to managed care plans has reached folkloric status. He argues that there is evidence that managed care, while perhaps generating lower medical costs, presents higher administrative costs for both the insurer and participating providers. He adds that managed care plans also force cost shifting to fee for service payers by demanding deeper discounts of providers. Both of these factors may actually increase total health care costs, rather than contributing to a decline. He reconciles the apparent conflict between the proliferation of

¹⁶⁶ Fraser I, Chait E, Brach C. Promoting Choice: Lessons from Medicaid Managed Care. *Hlth Aff.* Vol 17(15):165-174. September/October 1998.

¹⁶⁷ *supra* at 138

¹⁶⁸ *supra* at 155

managed care plans and declines in health care inflation occurring in the mid-1990s by crediting, instead, the convergence of a downturn in the insurance underwriting cycle, the recession of the early 90s, and the political support for managed care as an answer to cost inflation.¹⁶⁹

Long and Coughlin document a reduction in Medicaid expenditures associated with the enrollment of children in managed care plans. They note that such reductions were achieved primarily through use of lower rates of payment, without adversely impacting access or quality.¹⁷⁰ Rowland found mixed results relative to cost savings, with full risk capitation arrangements generating greater reductions in expenditures than primary care case management programs.¹⁷¹

Hurley and Rawlings examine the question of cost containment in a recent (2001) paper entitled "Who Lost Cost Containment: A Roster for Recrimination." They posit that the rise of premium costs in the late 90s is suggestive of a failure on the part of managed care to contain health care costs. They wonder whether health care costs ever really were in hand or were the downward premium trends of the mid-90s simply reflecting underbidding by insurers to attract enrollees. Cautioning that premiums are not entirely representative of cost, they concede that there was, in fact, a slowdown in medical expenditures during the early to mid-1990s, which were most pronounced in the hospital and physician sectors.¹⁷² They note, though, that the blame for managed care's failure to control premium costs over the longer term is one that must be shared by employers, providers, plans and consumers, with each playing a key role in the breakdown of its promise.

Lessons Learned and the Future

Managed care and the health care market are both moving targets, moving so quickly as to make predictions regarding the future rather difficult. Still, it seems fair to say that the status of managed care has come down a notch or two in the past several years as premium costs have begun to skyrocket once again.

The salient lessons that may be gleaned from the managed care experience to date are:

- Managed care plans tend to provide comprehensive benefit packages with less out of pocket cost to the consumer, at a more attractive price;

¹⁶⁹ Sullivan K. On the "efficiency" of managed care plans. *Int J Hlth Svc.* Vol 31(1):55-65. 2001.

¹⁷⁰ *supra* at 134

¹⁷¹ *supra* at 12

¹⁷² Hurley R, Rawlings RB. Who Lost Cost Containment? A Roster for Recrimination. *Mgd Care Qrtly.* Vol 9(4):23-32. 2001.

- Consumers, whose price sensitivity relative to insurance costs is high, tend to prefer managed care plans due to the lower financial costs of those plans;
- Consumers are generally satisfied with the financial aspects of managed care plans, but are less satisfied with the administrative features of the plan designed to control access to services;
- Managed care plans do impact utilization of certain services, but it is not clear that these plans adversely impact the quality of care;
- Evidence of managed care's ability to constrain health care costs is mixed; it is not clear whether today's rising health care costs reflect a failure of managed care or simply the correction of a competitive insurance market flooded by underbidding.

Rising premiums have encouraged purchasers to shift more and more risk to enrollees, in the form of cost sharing for coverage, reductions in the scope of coverage and increases in copayments for services.¹⁷³ If the economy remains in a slump and the job market loosens, these shifts will probably continue. Because managed care consumers are attracted to and satisfied with their plans' financial characteristics and relatively dissatisfied with the organizational aspects of those plans, increased enrollee cost sharing will likely fuel growing frustration with managed care. Moreover, Americans are voracious in their appetite for top-notch health care that is easily accessed, whenever and wherever they want or need it, but are loathe to pay high prices for it.¹⁷⁴ It is that basic dilemma which continues to plague policymakers as they move ahead into the 21st century.

It is important to bear in mind that the market has not really allowed managed care to operate in accordance with the conceptual framework originally designed for health maintenance organizations. These organizations were designed to make use of best practices, treatment protocols, and risk sharing arrangements to incent appropriate provider behaviors. Instead, they have evolved into variants that rely on negotiating positions and prior authorization to control costs. Perhaps the most important lesson to be learned here is that it is unreasonable to expect managed care to live up to its promises if it is not allowed to be implemented as intended.

¹⁷³ *supra* at 12

¹⁷⁴ *id*

OTHER LEVERS

Regulation of Health Insurance

Background

Issues surrounding the cost of health insurance are virtually inseparable from the cost of care and cost containment generally. While some have attributed rising premium costs to failures of managed care systems, others have suggested that, perhaps, health care costs have never really been under control, with the low premiums of the first half of the 1990s reflective of insurer underbidding in a competitive marketplace.¹⁷⁵ However, the reasons for the rise and fall in premium costs include factors both related to the underlying cost of care and to factors unrelated to those costs such as the underwriting cycle and a need to maintain profit margins.

Health insurance is often blamed as being a major contributor to the crisis in health care costs because it tends to cushion health services consumers from the true costs of care, contributing to market failure.¹⁷⁶ As the cost of coverage spirals upward (again, for reasons both related and unrelated to the underlying costs of care), there will likely be a trend toward increasing numbers of uninsured, particularly if the economy remains in a slump.¹⁷⁷ Increases in the numbers of uninsured individuals will place additional stress on providers' ability to deliver uncompensated care.¹⁷⁸ Providers – particularly hospitals – subsidize care for medically indigent persons through several mechanisms: public financing from tax revenues, uncompensated care pools where they exist, Medicare/Medicaid and disproportionate share payments as well as private financing via philanthropy and cost shifting to other payers.¹⁷⁹ The reality of limited resources threatens the viability of providers already operating at thin margins.

There is ample evidence that uninsured persons – and those persons faced with substantial cost sharing (as may be imposed in an effort to dampen premium increases and curb demand-side inflation) – have poorer access to care and lower use of health services.^{180 181} The uninsured are more likely to experience

¹⁷⁵ *supra* at 172

¹⁷⁶ *supra* at 21

¹⁷⁷ Miller JE. A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage. National Coalition on Health Care. November 2001.

¹⁷⁸ Smith BM. Trends in Health Care Coverage and Financing and Their Implications for Policy. *NEJM*. Vol 337(14):1000-1003. October 2, 1997.

¹⁷⁹ Cunningham PJ, Tu HT. A Changing Picture of Uncompensated Care. *Hlth Aff*. Vol 16(4):167-175. July/August 1997.

¹⁸⁰ Holohan J, Spillman B. Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance. Urban Institute New Federalism Program Briefing. Series B, No. B-42. January 2002.

potentially avoidable hospitalizations for conditions that could be more efficiently treated on an outpatient basis,¹⁸² if access to such care was reasonably available. When they do seek hospital care it is often at a point when their medical condition reaches a crisis point – making their care more costly.

The effectiveness of cost sharing mechanisms may be mitigated by the simple reality that a minority of patients generates the vast majority of health care expenditures.¹⁸³ Because these people are ill, they would likely receive services, regardless of the cost sharing design employed; the imposition of cost sharing in this situation is unlikely to influence the level of utilization. Use of cost sharing devices are probably only marginally effective in impacting levels and patterns of utilization.¹⁸⁴

Controlling the cost of insurance is, like other regulatory strategies, a lever policymakers may employ as part of a comprehensive cost containment program. While this approach may not exercise a direct impact on the cost of care, it carries with it the possibility of a substantial indirect effect on the cost and viability of the current system.

The concept of insurance – any type of insurance – is protection from individual, potentially catastrophic losses by spreading risk over a larger population. Health insurance is predicated on the same notion, with a bit of a twist. While there are many ways in which society strives to protect the health of citizens – for example, through efforts to maintain clean air and water – exposure to the risk of major expenses related to illness can be devastating. We seek to protect our assets should we become ill and we seek the ability to access expensive medical care which likely exceed our individual resources, should we need it. Health insurance is a form of income transfer, allowing those who are sick to obtain more medical care than they likely would if they were uninsured.¹⁸⁵

CPS data indicate that more than 200 million Americans were covered by private health insurance in 2000.¹⁸⁶ More than 80% of these people are non-elderly who receive benefits through an employer-sponsored plan.¹⁸⁷ While a substantial number of people are covered by self-funded plans, many participate in

¹⁸¹ *The Uninsured and Their Access to Health Care*. Kaiser Commission on Medicaid and the Uninsured. January 2001.

¹⁸² *id*

¹⁸³ *AHRQ Has New Data About Cost of Health Care*. Press Release, July 10, 2000. Agency for Healthcare Research and Quality, Rockville, MD.

<http://ahrq.gov/news/press/pr2000/meps96pr.htm>. June 14, 2002.

¹⁸⁴ Personal communication with Scott Leitz, director of the Health Economics Program, Minnesota Department of Health, June 13, 2002.

¹⁸⁵ Nyman JA. The Theory of the Demand for Health Insurance. *Division of Health Services Research and Policy Research Brief*. University of Minnesota School of Public Health. Vol 9(3). April 2002.

¹⁸⁶ CPS Website. http://www.ferret.bls.census.gov/macro/032001/health/h01_001.htm. May 20, 2002.

¹⁸⁷ *supra* at 121

commercial health plans, health maintenance organizations and not-for-profit Blue Cross Blue Shield plans. The federal Employee Retirement Income Security Act of 1974 (commonly known as ERISA) governs the conduct of all self-funded plans, but oversight of the business of health insurance products falls primarily to the states. This has been the case since 1945, when Congress enacted the McCarran-Ferguson Act, clarifying the states' leading role in the regulation of the insurance business,¹⁸⁸ a delegation of responsibility that is reaffirmed by ERISA.

Health insurance is important not only to those who are covered by it, but to the provider community as well. Providers rely on health insurance as a “guaranteed” revenue stream. Medicare, Medicaid or other state-funded benefits programs often do not pay 100% of provider charges and providers are restricted with regard to their ability to balance bill for the difference. The uninsured generally have the least ability to pay, leaving the privately insured to absorb much of the otherwise unreimbursed expense of providing services to the broader public. While the market power of payers often leads to the negotiation of contractual allowances (discounts from charges), this class of patients – the privately insured – represents one of the few realistic targets for provider cost-shifting. To the extent that providers are unable to recover the legitimate costs of producing care, their fiscal viability may be threatened, as may access to care.

Over the past several years, we have witnessed dramatic increases in insurance premium prices. Although the underlying causes for this inflation are debatable, it is clear that such increases will eventually have an impact on the numbers of people who are covered by private insurance, especially if the economy remains sluggish. Employers are already beginning to shift more of the costs – along with risks for costs - of health care to their employees.¹⁸⁹ If it continues, this trend may result in growth in the numbers of persons who are uninsured, despite their employment status, generating a potential growth in the numbers of people who rely on public benefits. This contingency holds obvious implications for state governments, many of which are facing difficulty in maintaining the health benefits programs they now provide due to shrinking budgets and health care cost inflation. These concerns help motivate public strategies to assure that private health care coverage remains affordable and available, forming the impetus for the regulation of the insurance industry.

Types of Regulation

States typically focus their regulatory efforts relative to health insurance in the following areas: licensure, business practices, financial standards, access to coverage, access to services and premium pricing/rating.

The most basic type of regulation applied to health insurers (commercial and otherwise) is the requirement of state licensure. While at its most fundamental

¹⁸⁸ *id*

¹⁸⁹ Swartz K. “Enron-ing” Health Insurance. *Inquiry*. Vol. 38(4):344-346. Winter 2001/2002.

level, licensure constrains entry into a market, it is also used as a mechanism to assure that insurers and others offering health benefits coverage (HMOs) meet certain financial standards.

Importantly, licensure involves a review of a company's financial status, including capitalization, investments and capacity to maintain reserves adequate to cover anticipated claims. These reviews are aimed at evaluating the current and likely future financial solvency of the plan, the primary goal of regulators.¹⁹⁰ The process of licensure also includes an assessment of whether the company is actually able to provide the coverage promised in the markets (group, small group, individual) they are entering.

Business practices such as marketing, advertising, claims processing systems and so on, are overseen by state regulators. Policy forms, language and disclosures are also subject to oversight, with consumer protections in mind. Standard terminology is often required, making it easier for consumers to understand and compare plan offerings and contracts. The provision of information to consumers is also the subject of regulation; many states specify the items of information insurers are required to disclose. This may include details as specific as the methods used by the company to share risk with providers (in the case of HMOs, for instance). Other states, like California, publish "report cards" that facilitate comparisons of cost and quality across plans.¹⁹¹

There are a variety of regulatory approaches employed to control access to coverage, particularly in the small group and individual markets. Insurance reforms enacted in HIPAA have their roots in state strategies. These strategies include guaranteed issue, guaranteed renewability, rating factors and community rating. Entry into an attractive and potentially lucrative market is sometimes predicated on an insurer's agreement to participate in somewhat less attractive markets, as well. Some states, Massachusetts, for example, require insurers covering more than 5,000 enrollees in the small group market to provide guaranteed issue policies in the individual market, as well.¹⁹² Similarly, a 1992 law required group carriers doing business in New Jersey to either offer individual coverage or pay an assessment to subsidize the losses of carriers operating in that market.¹⁹³ By the end of 1999, 50 states had implemented statutes requiring guaranteed issue and renewal of all products in the small group market; 7 states required guaranteed issue of all products and 9 required

¹⁹⁰ Structuring Health Insurance Markets: Protecting Consumers and Protecting Competition. Agency for Health Care Policy and Research. Summary of May 1998 ULP Conference. Website: <http://www.ahcpr.gov/news/ulp/ulpmarkt.htm>. May 22, 2002.

¹⁹¹ see for example: <http://www.hmohelp.ca.gov/pa>. June 6, 2002.

¹⁹² Massachusetts Division of Insurance. Bulletin 97-07:Implementation of the Massachusetts Nongroup Health Insurance Law. June 9, 1997.

¹⁹³ New Jersey Department of Banking and Insurance/New Jersey Individual Health Coverage Board/New Jersey Small Employer Health Benefits Program Board. Individual and Small Group Health Insurance Markets: Progress Report; August 1993-April 1996.

guaranteed issue of *some* products in the individual market. By that time, however, all 50 states required guaranteed renewal of individual policies.¹⁹⁴

State regulations also specify the conditions under which policyholders may add or drop dependents, including mandating coverage of adopted children equivalent to natural children and of handicapped children. Pre-existing condition clauses are in place in 50 states, limiting the waiting periods that can be imposed as part of benefits coverage for specific medical/physical conditions and limiting the maximum number of months an insurer can “look back” at an individual’s experience to impose a pre-existing condition restriction.¹⁹⁵ Again, restrictions imposed on the small group market by regulators are more stringent than those applied to companies doing business in the individual market.

Guaranteed renewability requirements define the extent to which consumers have the right to renew a policy at its anniversary date, without being subject to risk reevaluation. Such provisions assure that policyholders who become ill during the period of time a policy is in force aren’t subject to “churning” by the insurer. That is, the insurer’s ability to drop a high risk enrollee (or force disenrollment through marked rate increases) is limited and cannot be carried out for reasons designed to avoid risk or future claims. Similarly, some states limit insurers’ ability to preclude coverage for individuals with pre-existing medical conditions, prescribing the circumstances under which any such limitations may be imposed.

While states differ in their approach to access to coverage in the small group and individual markets, all states have laws that require state licensed health benefits companies to offer or include coverage for certain services referred to as mandated benefits.¹⁹⁶ The range of such services varies substantially from state to state, but can include but is not limited to access to alternative or complementary medical services such as chiropractic, naturopathy and acupuncture, maternity care for both married and unmarried women, newborn services, and mammography. Mandated benefits do generate increases in premium costs, but these increases are relatively modest.¹⁹⁷ Parity for mental health benefits, access to breast reconstruction services for mastectomy patients, and minimum inpatient stays for maternity care are now specified in federal law (see the 1996 Mental Health Parity Act, the 1998 Omnibus Consolidated and Emergency Supplemental Appropriations Act, and the 1996 Newborns’ and Mothers’ Health Protection Act, respectively). Costs associated with mental health parity have been documented as being negligible, when

¹⁹⁴ Chollet DJ, Kirk AM, Simon KH. *The Impact of Access Regulation on Health Insurance Market Structure*. DHSS. October 20, 2000.

¹⁹⁵ *id*

¹⁹⁶ *supra* at 178

¹⁹⁷ *Mandated Health Insurance Benefits and Health Care Costs*. Minnesota Department of Health, Health Economics Program Issue Brief 2001-02. July 2001.

benefits are offered within a managed care context or substantial, when benefits are not subject to managed care.¹⁹⁸

In addition, some states – Maine, for example – impose requirements on organizations that restrict enrollees to a network of participating providers. These requirements may include proof of sufficient provider participation to ensure adequate enrollee access to primary and specialty clinicians within reasonable distances or travel times from their home or workplace.¹⁹⁹

Many states regulate premium pricing for products outside the group market. This category of regulation includes the limitation of rating factors. The extent to which the premium is regulated depends on the state and the type of insurer – be it a commercial insurer, an HMO/PPO or a non-profit health and medical services plan such as certain Blue Cross/Blue Shield programs. Actuarial fairness is the objective of this regulatory approach, discouraging the strong incentive for health plans to segment the market and decrease their exposure to risk.

Some states, including New York and Minnesota, regulate minimum loss ratios for certain lines of health insurance business,^{200 201} above and beyond the minimum loss ratios established by the federal OBRA legislation for Medicare supplemental policies. These provisions effectively limit the proportion of the premium dollar that may be used to fund administrative costs and/or profit, thus guaranteeing the consumer a minimum direct health services value for his/her policy purchase.

Insurers – even not-for-profit insurers – are faced with incentives to segment risk to bolster earnings. In every population, there are some people who tend to incur higher medical expenses and those healthier individuals who generate very few, low cost claims. Insurers would prefer to provide coverage to people who are healthy and who are less likely to need expensive services.²⁰² Even when faced with constraints on segmentation, forces within insurance markets tend to incent resegmentation.²⁰³ For example, insurers, wishing to avoid underwriting losses and desirous of holding down rates of increase in premium prices, turn to industry rating (charging differing rates to groups depending upon the type of business – high risk or low risk – the group is engaged in) when health status rating is limited. Others may raise premiums substantially at the end of the

¹⁹⁸ Varmus HE. *Parity in Financing Mental Health Services: Managed Care Effects on Cost, Quality and Access*. National Advisory Mental Health Council, NIH. May 1998.

¹⁹⁹ see 24-A MRSA c56A, subchap 1, §4303.

²⁰⁰ New York State Insurance Department Website. Selected Health Regulations. <http://www.ins.state.ny.us/hregindx.htm>. May 23, 2002.

²⁰¹ Minnesota Statutes 2001, Chapter 62A.021, Subdivision 1. Loss Ratio Standards.

²⁰² This is interesting phenomenon turns the social theory of insurance on its head. Insurance is intended to spread risks over a broad population, to minimize harm to individuals within the group. Market segmentation works counter to that notion.

²⁰³ Risk-Spreading or Risk Adjustment Mechanisms. Georgetown University. Website: http://www.georgetown.edu/research/ihrp/chep/Risksd-adjkp_wa.htm. May 22, 2002.

allowed underwriting period for pre-existing conditions, to reflect the perceived increase in their risk. Premium regulation – along with other strategies such as guaranteed issue and renewal requirements – are designed to address this issue.

Experience rating is the practice of pricing an insurance policy based on the historical claims experience for that individual or group being written. In this case, a small group with one very sick member can drive up the rates for the entire group, yielding coverage unaffordable and resulting in protection from future risk for the insurer. Community rating is the opposite of experience rating, where the premium for any person enrolling in the benefits plan is arrived at by considering the health care costs of all persons in the community or area in which the plan is offered. Neither characteristics (such as health status) nor experience of particular individuals is considered in the rate calculation, rendering this approach the closest approximation of social insurance we have through our private market mechanism. In 1999, 13 states prohibited insurers from factoring health status into their rate setting and 21 states limited the extent to which rates could be adjusted for health status.²⁰⁴

There are variants of community rating that incorporate geographic factors (allowing rates to differ based on the experience of the community in a defined geographic locale as a segment of a larger community or market) or demographic factors (allowing rate adjustments for deviations between the rated group's average age and gender distribution and that of the community's average age and gender distribution). Often, insurers' ability to modify rates for demographic or geographic factors is limited to prescribed bands; that is, rates may vary but only within a defined range say, plus or minus 20% of the average community rate.²⁰⁵ In 1999, one state (New York) prohibited the application of age bands in small group markets; only two states (New York and New Jersey) prohibited that practice in the individual market.²⁰⁶

The regulation of insurers also varies by type of insurer. The rules applied to commercial indemnity products will differ from those applied to health maintenance organizations and non-profit Blue Cross Blue Shield plans.

As alluded to earlier, there is federal law that seeks to influence the business of private health insurance. ERISA, HIPAA, the ADA, the Social Security Act, the Civil Rights Act and the tax code each impact health insurance.²⁰⁷ ERISA and HIPAA are two of the most important pieces of federal legislation relative to health benefits coverage. ERISA generally serves to exempt self-funded plans from much state regulation; this creates an attractive haven for larger firms that are able to afford self-funding, allowing a business to offer benefit plans that are

²⁰⁴ *supra* at 192

²⁰⁵ *supra* at 178

²⁰⁶ *supra* at 192

²⁰⁷ *id*

exempt from state rules and mandates. Among other things, HIPAA establishes portability of private coverage for subscribers, establishes certain renewability guarantees, prohibits discrimination against less healthy individuals within groups who are seeking coverage and requires certain minimum benefit mandates. These mandates include minimum hospital stays for maternity and newborn services, breast reconstruction following mastectomy and the strengthening of mental health parity standards for large groups.

Impact of Insurance Regulation

The impact of insurance regulation differs in the group and individual markets and is not altogether clear. Although some had argued that the guaranteed issue requirements implemented by states and imposed by HIPAA on the group market would encourage insurers to flee the market, Chollet and colleagues found no evidence of that result in group markets.²⁰⁸ In fact, they found just the opposite to be true. The imposition of guaranteed issue rules for all products appears to have resulted in there being more insurers operating in any given market and, arguably, more competition. In those states where guaranteed issue rules for groups are less comprehensive, the result is similar, though more modest.²⁰⁹

The number of insurers operating in individual markets was less impacted by guaranteed issue rules. However, these rules appear to have affected the relative share of the individual market enjoyed by different types of insurers. Mandating guaranteed issue of only some products has been found to favor commercial insurers; mandating guaranteed issue of *all* individual products favors BCBS and HMO plans over commercials.²¹⁰

Guaranteed renewal rules seem to vaguely favor insurers attaining greater economies of scale (generally larger insurers); this phenomenon may, in turn, favor consumers, because the lower average costs generated by such economies may lead to more affordable premiums. Chollet *et al* also found that limits on insurers' ability to impose pre-existing condition exclusions resulted in a greater concentration of insurers within a market, favoring larger plans over smaller ones. Investigators found no impact of mandatory renewal on the individual market.²¹¹

Limiting exclusions of pre-existing conditions has had little or no impact on individual markets and have not resulted in any substantial adverse selection. Group markets with these limits tend to be more concentrated; that is, they have

²⁰⁸ *supra* at 192

²⁰⁹ *id*

²¹⁰ *id*

²¹¹ *id*

fewer numbers of insurers, each with larger market shares, favoring larger firms over smaller ones.²¹²

The issue of mandated benefits is one that often serves as the topic of lively debate. While they assure access to certain services and/or providers, insurers sometimes argue that they can be cost drivers. However, the literature presents mixed evidence on this point. As mentioned earlier, some analysts have found that while there is indeed some cost impact of mandates, it is relatively modest.²¹³ Hall, *et al*, argue that elimination of mandated benefits requirements is not likely to reduce the cost of insurance in any substantial way, citing the historically poor sales performance demonstrated by “bare bones” policies.²¹⁴ These investigators hypothesize that eliminating these rules may, in fact, destabilize the markets, removing the level playing field facing all competitors and forcing traditional plans out.²¹⁵

The published literature includes a number of investigations of the impact of mental health parity laws on the structure of the insurance market. The articles reviewed for this paper - which included literature reviews of extant publications - failed to find any substantial negative impact of this regulatory strategy. Utilization of mental health and substance abuse services was found to have increased, particularly for children, in managed care programs, *without* increases in costs. This net effect appears to be attributable to a decline in hospital days (but not in the number of admissions). At the same time though, groups not subject to the mandate tended to exhibit similar increases in treatment prevalence,²¹⁶ implying that there was a general trend towards increased use of mental health services in the market studied.

The report published by the National Advisory Mental Health Council found that mental health parity requirements have little impact on costs, perhaps less than a 1.5% impact on premiums, with a simultaneous decline in total health care costs.²¹⁷ While the Council was unable to determine any impact of the mandates on the quality of care, they found that the combination of parity and managed care results in increases in the proportion of mental health services obtained on an outpatient basis. Children especially have experienced increased access to specialty mental health services.²¹⁸

²¹² *id*

²¹³ *supra* at 195

²¹⁴ Hall MA, Wicks EK, Lawlor JS. HealthMarts, HIPCes, MEWAs, and AHPs: A Guide for the Perplexed. *Hlth Aff.* Vol 20(1):142-153. January/February 2001.

²¹⁵ *id*

²¹⁶ Zuvekas SH, Regier DA, Rae DS, Rupp A, Warren WE. The Impacts of Mental Health Parity and Managed Care in One Large Employer Group. *Hlth Aff.* Vol 21(3):148-159. May/June 2002.

²¹⁷ National Institute of Mental Health. *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council.* NIH Publication No. 00-4787. 2001.

²¹⁸ *id*

The impact of rate regulation and the impact of broad “packages” of market reforms, generally, are ambivalent. Marquis and Long²¹⁹ examined the impact of reforms implemented in eleven states and the District of Columbia during the mid-1990s. These reforms included guaranteed issue and the elimination of health status as an allowed rating factor. They failed to find any impact of these reforms on small group markets. At the same time, they were unable to conclusively find that the reforms were of any help, relative to reducing variability in premium rates or stimulating any substantial expansion of employer-based coverage.

Chollet, *et al*,²²⁰ found that states that limit overall rate variation have markedly more insurers operating in the group market than states that do not. Similarly, they found that the requirement of pure community rating had only a slight (negative) impact on the number of insurers operating in a group market. These same constraints appeared to exercise no significant effect on the number of insurers operating in individual markets. However, they did tend to concentrate market share in the hands of Blue Cross plans, as opposed to commercial products. Regulation of minimum loss ratio failed to result in any notable impact on the number of insurers writing coverage in either market.

Using CPS data for 1990-1996, Zuckerman and Rojan²²¹ examined the impact of market reforms on access to coverage. Their study also failed to find any significant impact of comprehensive small group reforms on the rates of uninsured. However, they point out that these reforms have not generated any adverse impacts, either, and may have actually served to stem the erosion of private coverage. These findings are similar to those made by Sloan and Conover,²²² using data from 1989-1994.

Lessons Learned and Prospects

The efficiency of market regulation remains an open question. The evidence suggests that this type of regulation does *not* harm markets; at the same time, the efficacy of such efforts is unclear. Despite all of these efforts, increases in premium rates for all sectors of the market have caught everyone’s attention over the past several years. Premiums for employer-sponsored insurance increased an average of 11% between 2000-2001, the greatest rate of increase since 1993 and the fifth consecutive year of growth in the rate of increase.²²³ It appears that much of the fluctuation in premium rates is attributable to the underwriting cycle,

²¹⁹ Marquis MS, Long SH. Effects of “Second Generation” Small Group Health Insurance Market Reforms. *Inquiry*. Vol 38(4):365-380. Winter 2001/2002.

²²⁰ *supra* at 192

²²¹ Zuckerman S, Rojan S. An Alternative Approach to Measuring the Effects of Insurance Market Reforms. *Inquiry*. Vol. 36(1):44-56. Spring 1999.

²²² Sloan F, Conover C. Effects of State Reforms on Health Insurance Coverage of Adults. *Inquiry*. Vol 35(3):281-293.

²²³ *supra* at 12

which generally moves over a three-year period, with premium prices lagging slightly behind general changes in health care costs. Hurley and Rawlings characterize criticism of the underwriting cycle akin to “bemoaning gravity.”²²⁴ Perhaps that cycle and its influence on premium fluctuations will, like gravity, always be with us.

Still, it seems important to bear in mind the possibility that market reforms have prevented or slowed erosion of coverage. While not proven, the importance of this potential cannot be ignored by those struggling to maintain the stability of the market.

What does the future hold for insurance regulation? While the market may be able to control cost and, to some extent, quality, it cannot work to achieve an efficient or equitable distribution of health care resources across the entire community.²²⁵ To the extent that is the policymaker’s goal, some form of regulatory intervention will always be required. While we may see the evolution of more elegant risk adjustment techniques, it is therefore unlikely that we will witness any substantial retreat from the market reforms already in place.

²²⁴ *supra* at 172

²²⁵ Enthoven AC, Singer SJ. Markets and Collective Action in Regulating Managed Care. *Hlth Aff.* Vol. 96(6):26-32. November/December 1997.

Conclusion

Where Have We Been?

For the better part of thirty years, health care cost containment has been one of the most difficult challenges facing policymakers. Efforts to constrain costs can be categorized using a simple taxonomy: strategies targeted at impacting supply, strategies targeted at controlling price, and strategies targeted to influencing demand. As discussed in this paper, variations of each of these strategies have been used in any number of states across this country. Certificate of Need has been in place – at one time or another – in a majority of the states. Hospital rate setting was a somewhat less popular alternative, but with notable results. Managed care is pervasive, as is regulation of the insurance industry.

Although policymakers have often embraced cost containment with hope and enthusiasm, these strategies have not always restrained cost growth as anticipated or they have been unsustainable. Several, however, did succeed in reallocating resources and increasing funds available for indigent care.

We are again facing rising health care costs and the potential of devoting an ever-increasing share of our gross domestic – and state – products to this commodity. This prospect is especially daunting when the economy is faltering and states are faced with severe budget deficits.

Historically, though, it is in times just as these when policymakers – private and public – have made their boldest moves toward cost containment. Nixon's ESP was instituted at a time when the cost of the war in Vietnam was demanding austerity at home. Employers sought innovations in insurance coverage when a stagnant economy and increasing competition forced them to look for ways to save benefits expenses. States designed and instituted cost containment programs in response to sluggish economies, shrinking federal revenues, and demands from constituents. As important, many of the strategies used over the past thirty years did not, in fact, reduce spending growth but did reallocate expenditures. Resources "saved" by cost containment efforts were often redirected to the uninsured through the subsidization of indigent care.

Noticeably absent, though, were coherent, systematic approaches to cost containment. Instead, these attempts were made reactively and in a fragmented, uncoordinated manner. The extent to which individual efforts actually worked together toward a unified objective is small. Not surprisingly, then, the overall effectiveness of past cost containment efforts is fairly disappointing. Standing at the brink of another health care cost crisis, both public and private health policymakers are facing what may be their next best opportunity to design and implement meaningful and effective cost containment initiatives.

Where Are We Headed?

We are already beginning to see the outlines of a new iteration of cost containment efforts. The new wave of efforts look like a variation on a historical theme – more of the same disparate attempts at controlling supply, price, and demand.

Most visible are the attempts to reign in one of the leading factors in rising health care expenditures: the price of prescription drugs. States are exploring the expanded use of drug formularies, using their Medicaid market leverage to gain deeper discounts from pharmaceutical manufacturers in return for placement of drugs on the preferred formulary listing, and initiating joint purchasing among state agencies and between the public and private sectors.

Insurers are building benefits designed to limit consumer demand for costly drugs through multi-tiered prescription drug pricing. Usually three-tiered, consumers face different co-pay requirements depending upon the class of drug they are prescribed. Generic drugs are usually subject to the lowest level of co-payments, encouraging patients to opt for them as often as possible. Brand name drugs on a preferred formulary are subject to the next lowest level of co-payment. In this instance, an insurer identifies brand name drugs it believes to be cost effective. Consumers who do not opt for a generic drug are encouraged to purchase a second-tier drug by its relatively low co-payment. Finally, third tier drugs are brand name pharmaceuticals that fall outside the preferred formulary. Consumers purchasing these drugs are often subject to steep cost sharing requirements, intended to persuade them to opt for a less expensive alternative.

The redesign of health insurance coverage is also becoming popular as a means to restrict consumer demand. Whereas increased premium sharing and nominal deductibles and co-payments were common premium cost containment strategies over the past decade, the transfer of risk from insurer to consumer is now gaining ground. This trend is reflected in the growing number of high deductible insurance plans now sold in the small group and individual markets. It is not uncommon for these plans to incorporate \$2,500, \$5,000, or \$10,000 deductibles, protecting the subscriber from only the most catastrophic of losses. While this type of coverage is suitable for individuals financially capable of self-insuring for most health care expenses, it does not provide comprehensive coverage for many people.

Finally, disease management is growing as policymakers come to appreciate that health care cost growth is driven in part by the demands of an aging population and more chronic illness. Disease management (DM) ranges in form from the development and implementation of physician guidelines or patient education mailings to sophisticated initiatives involving nurse case managers at the plan or health system level. There are programs that focus on populations of chronically ill patients – such as persons with diabetes – and some target individual patients

with high cost conditions (for example, a patient with traumatic brain injury). A third form of DM involves the monitoring of an entire population, working to improve provider compliance with, evidence-based, best practices and to improve patient outcomes.²²⁶ The overall aim of these efforts is the management of demand for services and the limitation of the supply of services, assuring that consumers get only those services most likely to address their needs.

Cost sharing is also on the rise as a strategy to limit cost and demand. There is a marked trend by employers to shift a greater proportion of premium costs to the employee, especially relative to the cost of dependent coverage. This accomplishes two objectives. First, it simply reduces the benefit cost for the employer, helping to hold the line on the benefits budget. Second, it may reinforce the notion that the benefit is not free, imparting a greater cost sensitivity to the employee.²²⁷

These structural changes in health coverage do not bode well for efforts to constrain growth in the number of uninsured. The extent to which consumers are financially compromised by the cost of coverage will be reflected in an increased uninsured population. This phenomenon, in turn, will contribute to growth in the level of uncompensated care, increased stress on marginal providers (especially safety net providers) and increased cost shifting, creating a situation that is simply untenable in the long run.

We have important social objectives for the provision of health care in this country. That is, we have a fundamental desire to see that necessary medical care is provided to those persons who need it. While the individual strategies that have been tested or are now being implemented may have potential, the synergy of the market place appears to challenge their collective ability to contain costs.

Where to Now?

The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand, building a comprehensive, tripartite strategy that is sensitive to the complexities and idiosyncrasies of the health care marketplace. Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them. NASHP is committed to working with states and others to design such strategies to build systems of care that balance cost, quality, and access.

²²⁶ Mechanic RE. Disease Management: A Promising Approach for Health Care Purchasers. *Executive Brief*. National Health Care Purchasing Institute. May 2002.

²²⁷ Swartz K. The View From Here: Where is Efficiency Leading Our System of Health Insurance? *Inquiry*. Fall 1997.