

# Tracking The Demise Of State Hospital Rate Setting

*Managed care and regulatory failure combined to overturn hospital payment systems in Massachusetts, New Jersey, and New York—but not in Maryland.*

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**ABSTRACT:** From its once preeminent position in state health policy, prospective hospital rate setting has declined in use from more than thirty states in 1980 to two today. This essay tracks the trend toward deregulation in various states—especially Massachusetts, New Jersey, and New York—and examines the continuation of rate set-

ting in Maryland. Principally, the decline reflects the development of managed care and capitation as alternative means to control health spending growth. This trend represents both an evolution in prospective payment methodology and a renewed preference for private over public-sector price controls.

142

## INTRODUCTION

ON 1 JANUARY 1997 New York State deregulated its expansive hospital rate-setting system that dates back to 1969. Rather than breaking new ground, this move is only the latest in a series of deregulations that reflect a dramatically changed health policy world since 1980, when prospective rate setting was a key policy tool used by states to control rising medical costs. At that time more than thirty states embraced some variant of prospective payment regulation, and experimentation was under way to combine all public and private payers into “all-payer” rate-setting models. New Jersey’s version was the forerunner of the Medicare prospective payment system (PPS).<sup>1</sup>

Rate setting was developed with the encouragement of the federal government through two acts of Congress in 1972 and 1983 and with support from successive administra-

tions. Indeed, President Jimmy Carter’s ill-fated 1979 hospital cost containment legislation was an attempt to replicate nationally this favored cost containment tool.<sup>2</sup> Now, in the mid-1990s, state rate setting is nearly gone; most major systems have been deregulated during the past ten years. Despite the continued dominance of prospective payment in Medicare, federal support of state rate setting vanished during the 1980s. Once-vibrant interest from the health policy community also has dissipated.<sup>3</sup>

Although this policy model could pass from the scene with little notice, the experiences of states that have chosen to deregulate and states that continue to regulate hold lessons for health policy and the political system. This essay examines factors that led states to drop rate setting and identifies key lessons from this long experience.

■ **METHODOLOGY.** Results presented here are based on in-depth case studies of

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rate-setting systems in Maryland, Massachusetts, New Jersey, and New York, with special attention paid to the deregulation process in the latter three. In each state, interviews were conducted with hospital, insurer, business, labor, and consumer representatives, along with legislative and executive branch officials. Information on the status of rate setting in other states was obtained by a mail survey of hospital and state officials.

**DEVELOPMENT AND PERFORMANCE**

Prospective setting of hospital rates took shape in its modern form in the late 1960s in states with high and rapidly growing hospital and Medicaid costs. States sought to address inadequate controls implicit in the fee-for-service market and saw prospective payment as a potentially effective tool. Early versions used per diem measures; later and more sophisticated versions evolved to per case/diagnosis measures that are at the core of the diagnosis-related groups (DRGs) for Medicare PPS.<sup>4</sup>

Research has found that states with mandatory controls were able to reduce their rate of growth in per discharge and per capita inpatient costs relative to states with voluntary, weak, or no controls; evidence is more divided

on the effect of rate setting in holding down the rate of growth in overall health care system costs.<sup>5</sup> All of these conclusions are based on research from the pre-1985 period; data suggest that the cost-control performance of most state systems declined dramatically after 1985.<sup>6</sup>

Critics predicted that rate controls would inhibit the development of new models such as health maintenance organizations (HMOs). But the factors that led states to adopt rate setting—high health care and hospital costs—also encouraged HMO growth. Except for New Jersey, lead rate-setting states had HMO penetration rates well above the national average during the 1980s and 1990s, a development that severely undermined the stability of these systems.<sup>7</sup> Because rate-setting models usually included reimbursement of charity care costs to hospitals, access for uninsured persons was improved in the regulated states, albeit inefficiently.<sup>8</sup> Two studies found negative effects on the quality of care, although the subject has not been well examined and assessments are divided.<sup>9</sup>

**RATE SETTING'S DECLINE**

Beginning with Wisconsin in 1986, states that had been in the forefront of rate setting began to abandon it. Exhibit 1 lists key deregulations since 1986, as well as states that maintain

**EXHIBIT 1  
Status Of State-Based Hospital Rate Setting**

Deregulations since 1986	Continuing rate setting	Budget review/control
Wisconsin (1986)	Maryland	Arizona
Washington (1989)	West Virginia	Connecticut <sup>a</sup>
Massachusetts (1991)		Florida
New Jersey (1992)		Oregon
Connecticut (1994) <sup>a</sup>		Rhode Island
Maine (1995)		Vermont
Minnesota (1995) <sup>b</sup>		
New York (1996)		

SOURCE: Author's survey; data signify year of legislative enactment of repeal.  
<sup>a</sup> Connecticut retained state approval of hospital budgets while deregulating its charge control authority.  
<sup>b</sup> Minnesota enacted rate setting for non-managed care plans as part of its 1992 "MinnesotaCare" reform legislation; the controls were never implemented and were repealed in 1995.

some form of rate setting or budget control today. Each state's deregulation involves a mix of political, economic, and institutional factors. Several consistent themes emerge from their collective experience, each of which is discussed in turn. At the end of each section, the contrasting situation in Maryland, where rate setting continues undisturbed, is also discussed.

■ **THE COLLISION WITH MANAGED CARE.** In 1972 and 1973 Congress passed laws to encourage states to experiment with rate setting (P.L. 92-603) and to foster the development of HMOs (P.L. 93-222). Throughout the 1970s and 1980s, while HMO growth was small, these two initiatives largely avoided each other. In the 1990s the systems collided. The key contact point involved the treatment of HMO/hospital payments within each rate-setting structure. All mandatory systems had to decide up front whether to require HMOs to pay state-regulated hospital charges or to permit negotiated rates of payment lower than approved charges paid by Blue Cross, commercial carriers, and public payers.

The architects of the Massachusetts all-payer system in 1982 chose to allow HMOs unlimited discounting authority to encourage their growth, then less than 2 percent of the private market. By 1991 HMOs were dominant forces, and Blue Cross's statutory 7.5 percent discount off charges became less a competitive advantage and more a millstone in the context of much larger HMO/hospital discounts. When public officials had to choose in 1991 whether to bring HMOs under the rate-setting umbrella (a politically challenging task) or to let all plans compete on the same basis, deregulation passed overwhelmingly.<sup>10</sup>

This same conflict between the imperatives of a new managed care/contracting environment and the requirements of a stable rate-setting system emerged in every regulated state. The New York Prospective Hospital Reimbursement Methodology (NYPHRM) authorized full HMO discounting in 1988, subject to routine state approval; the ensuing erosion of the NYPHRM's reach as HMOs grew led one longtime observer in

1995 to declare that "the system has already been *de facto* deregulated."<sup>11</sup> Although New Jersey officials attempted to prohibit HMO discounting in their DRG system, observers indicate that the practice was prevalent. Connecticut officials saw discounting rules as the principal source of controversy in their rate-setting system.

Maryland has not escaped the managed care pressures evident in other states; its HMO penetration rate is among the highest in the nation. In spite of this, regulators in Maryland have tightly and successfully limited negotiated discounts (available to all payers, not just HMOs) to no more than 4 percent, and only to insurers who provide certain consumer benefits such as open enrollment. Although payers in Maryland privately grumble, few openly call for deregulation, and none can claim to be suffering inordinately in the rapidly growing Maryland managed care market.

■ **REGULATORY FAILURE.** Public and private officials in all deregulated states agree that the statutes and regulations needed to sustain their rate-setting systems were complex and often incomprehensible. One New Jersey insurance official likened their system to "a methadone program, a guaranteed bottom line every year, and no one could understand how it worked." The former Senate Health Committee chairman in Massachusetts called their statutes "like Sanskrit—no one could understand them, even the hospital people." One study of NYPHRM noted that its complexity "is the source of considerable black humor within the state."<sup>12</sup>

The confusion fed suspicions that rate setting was subject to excessive gaming by powerful players, most often by the teaching and urban hospitals that benefited disproportionately from the redistributive aspects of the systems. Criticisms from less influential hospitals and other interests often led legislators and regulators to refine their systems to accommodate dissenting parties' concerns. The adjustments most often resulted in greater incomprehensibility and the generation of still further demands.

Maryland's enabling statute, which has re-

mained unaltered since its 1971 enactment, differs from those of other states in its simplicity and the extent of the authority delegated to regulators at the Health Services Cost Review Commission (HSCRC). The commission has used its autonomy to promote its set of core principles—cost control, payer equity, access, and institutional stability—while experimenting with an array of alternative payment methodologies under the rate-setting umbrella. The HSCRC now is authorizing numerous Maryland hospitals to engage in forms of capitation and global payments that create an image of openness and flexibility not normally associated with hospital rate-setting systems.

■ **THE CHANGING INTEREST-GROUP LANDSCAPE.** State rate setting was enacted because of self-interest lobbying by key power groups, not because of any mobilization by citizens. The American Hospital Association (AHA) supported state rate setting in the 1970s to avert federal controls (indeed, Maryland's rate-setting statute was written in the offices of the Maryland Hospital Association). The Health Insurance Association of America (HIAA) vigorously supported regulation to defend against cost shifting from Blue Cross and public payers. Business and labor supported controls to hold down the cost of their indemnity-based plans. Finally, legislators and executive branch officials embraced rate setting to contain rapidly growing Medicaid costs.

All states that deregulated first saw major shifts in the positions of key stakeholder groups that began to see regulation's costs outweigh its benefits. The steady growth of managed care was a key element in changing attitudes. Blue Cross plans moved from acquiescence to hostility as they moved to managed care to dig out of their respective financial crises. The HIAA discontinued its active support in the late 1980s as its larger members moved to managed care. Business groups, labor unions, and state government health purchasers (chiefly Medicaid) dropped their support as they realized their own capacity to negotiate rates of payment that were far lower

than public regulatory systems would permit.

Although the AHA dropped its support for rate setting in 1980, one year after the defeat of President Carter's hospital cost-control plan, state hospital groups provided crucial support for the continuation of rate setting on their own turfs. But states that deregulated first saw a splintering of support among various hospital groups. This was most notable in New Jersey, where teaching and urban institutions—unhappy with the New Jersey Hospital Association's acceptance of deregulation—formed their own groups in an unsuccessful effort to salvage rate setting. Other splits were visible in Massachusetts and New York.

Some Maryland insurers and HMOs quietly question the need for continued rate setting; other key groups are less doubtful of its value. Central to their appreciation is the continuing federal waiver that requires Medicare to pay hospitals according to state rules. Estimates of the financial value of the waiver vary between \$200 million and \$300 million in annual hospital payments that would be lost without regulation. Unlike waivers for Massachusetts, New Jersey, and New York, which were granted administratively by the Health Care Financing Administration, Maryland's waiver was written into federal statute in 1980.<sup>13</sup> Virtually all knowledgeable observers in the state regard the waiver's maintenance as crucial to the survival of the rate-setting system. Although some business voices have called recently for a review of the system, the calls have been restrained. The hospital community remains strongly in support despite growing competition from nonhospital providers. Maryland's legislature and executive branch, which authorized a review of rate setting in 1995, strongly affirm confidence in the system in the statute's preamble.<sup>14</sup>

■ **THE LINK TO POLITICAL CHANGE.** Most rate-setting deregulations occurred as states experienced political alteration from Democrat to Republican or Independent control. In 1991 newly elected Massachusetts Governor William Weld, a Republican, made hospital deregulation a central part of his

first-year agenda. In 1992 newly elected Republican majorities in the New Jersey Assembly and Senate bargained with Democratic Governor James Florio to end that state's pioneering DRG system. In 1995 newly elected Governor Angus King, an Independent, worked with a new Republican majority in the Maine Senate to eliminate their twelve-year-old system. In 1995 New York's first Republican governor since 1974, George Pataki, placed NYPHRM deregulation squarely on the state's policy agenda.

While this "political transition" element reflects a recognizable antiregulation theme for Republicans, it should be noted that prior eras of Republican control in these states did not produce deregulation efforts. New York's Nelson Rockefeller presided over the implementation of rate setting in the early 1970s. New Jersey's Thomas Kean actually convinced the Reagan administration to grant the Medicare waiver that was central to the DRG system's operation. Less than a causal event, the electoral shift served as a "focusing event" that coalesced deregulation forces to take advantage of the new opportunity.<sup>15</sup>

In Maryland long-term Democratic majorities in both branches of the legislature as well as continued Democratic control of the governor's office set the state apart from deregulated states. Key policymakers are readily familiar with the major achievement attributed to Maryland rate setting: a drop in hospital costs per admission from 25 percent above the national average in 1977 to more than 6 percent below the national average in 1995. Policymakers claim that this reduction has saved government, labor, business, and consumers more than \$10 billion.

In sum, four factors have enabled Maryland to keep rate setting on track: (1) the ability to prevent HMOs from engaging in competitive discounting; (2) the statutory flexibility provided to system managers to adapt to new circumstances; (3) the maintenance of the Medicare waiver that places regulatory opponents on the financial defensive; and (4) the maintenance of Democratic control in the executive and legislative

branches. Until some or all of these change, the Maryland system is likely to continue.

■ **PICKING UP THE PIECES.** The elimination of rate setting has not resulted in the abandonment of commitments to provide access or to meet other health policy goals, although the nature of the states' responses has varied widely. Two broad responses can be seen: first, an attempt to reconstruct uncompensated care pools to assist uninsured persons and to retain federal disproportionate-share matching dollars; and, second, an effort to redirect public funds from institutional to individual subsidies.

In Massachusetts a \$315 million uncompensated care pool was retained in the 1991 deregulation statute, although hospital pool payments that had been intended as pass-throughs to private purchasers under regulation were increasingly borne by hospitals in an environment of tightened payer negotiations. As competitive pressures mounted in 1996, hospitals aggressively began lobbying for a new method to share the costs of providing charity care. Meanwhile, the state is expanding coverage to increasing numbers of uninsured residents through a Medicaid 1115 waiver and a twenty-five-cent increase in the cigarette excise tax.

New York officials were determined in 1996 to avoid the mistakes made in Massachusetts relative to the financing structure of the pools. Their new statute permits hospital purchasers to pay a 32 percent surcharge through the hospital or an 8 percent surcharge directly to one of eight regional pools. Their novel solution is intended to make sure that purchasers—and not hospitals—provide revenues for the pool, while avoiding federal Employee Retirement Income Security Act (ERISA) preemption.<sup>16</sup> The new law also maintains a generous subsidy for graduate medical education purposes, albeit at reduced levels. The state also is moving to expand its Child Health Plus Program and other access programs to provide greater levels of coverage for uninsured children and others.

New Jersey lawmakers chose another path for refinancing their pool in 1992 in the wake

of a federal court decision that found it to be in violation of ERISA.<sup>17</sup> A sizable surplus in the state's unemployment insurance trust fund was used to finance nearly \$1.28 billion in hospital charity care costs from 1993 to the end of 1995. Although lawmakers had promised not to use the fund after three years, a 1996 stalemate over a successor financing vehicle resulted in two more years of funding from this source until the end of 1997 at reduced levels of \$310 million in 1996 and \$300 million in 1997. In the 1992 reforms decreasing funds directed to the pool were promised to be transferred to increasing insurance subsidies for uninsured residents with incomes below 250 percent of the federal poverty level. That program was not launched until 1995, and subsidies have been capped at \$50 million for 20,000 persons, far below the 1992 commitment of \$150 million. In New Jersey a tax-cutting agenda has taken precedence over subsidies for more than one million uninsured residents.

**STATE RATE SETTING'S LEGACY**

The book is not yet closed on state rate setting, but the end is near. Four lessons emerge from the rate-setting experience: (1) Its decline reflects more an evolution in the prevailing form of prospective payment from per diem and per case to capitation than a revolution in health-sector regulation; (2) its demise signals a different and more limited role for states in the health sector; (3) the experience illustrates how regulatory targets can "game" systems to their own advantage; and (4) it demonstrates that states retain some ability to achieve complex regulatory objectives.

■ **EVOLUTION MORE THAN REVOLUTION.** In modern times we have seen four methods to pay the hospital: retrospective fee-for-service, per diem, per case/DRG, and capitation. The latter three represent forms of prospective payment, from least to most re-

strictive. State prospective rate setting focused chiefly on per diem and per case methods that are now being abandoned in the move toward capitated models. Early rate-setting attempts to control hospital costs were largely a reaction to fee-for-service reimbursement methods prevalent during the 1960s and 1970s. During that period HMOs were a tiny part of the market, and private purchasers—chiefly businesses and labor unions—had few alternatives to the force of

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government to counter the power of the provider community—chiefly hospitals and physicians.

Today, health service purchasers show sophistication and clout in buying services for their respective members. They can negotiate payments on their own that are far more beneficial for their clients than those obtained from government-led, politically influenced bargaining. Rather than

rejecting prospective payment, they are moving to a newer form of prospective payment—capitation—that combines all medical (not just hospital) services into one price. Some business leaders who supported rate setting in its early development understood it to be a transitional arrangement until private payers could harness their own leverage.

This transition to capitation also epitomizes the less significant role of the acute hospital in the new health care system. Most rate-setting programs were established in the 1960s and 1970s, when inpatient hospital services represented the vital center of the system. Today, outpatient and home health services have sharply diminished the role of inpatient acute services.

■ **A DIFFERENT AND MORE LIMITED ROLE FOR GOVERNMENT.** Deregulation also represents both a rejection of the role of government as a price setter and an explicit move toward market-based mechanisms. The architects of state rate-setting systems were most often passionate believers in the role of

government as the driver of health policy—and frequently envisioned rate setting as an evolutionary stage to stronger and more expansive state and national controls. The public utility model for hospitals, popular with many rate-setting pioneers, is a direct casualty in this transition. Rate setting's denouement also includes rejection of an all-encompassing role for states in setting health system direction.

However, the states that are abandoning rate setting have not foreclosed other opportunities for intervening in the health care system. States have continued to seek to expand coverage to uninsured populations, through direct insurance subsidies such as in New Jersey, through Medicaid restructuring such as in Tennessee, and through insurance market restructuring such as in New York. States also are moving aggressively to respond to consumer and provider complaints regarding the practices of HMOs and other managed care entities in the new health care system. The ultimate impact of this new spate of state regulation remains to be seen.

■ **GAMES, GAMES, GAMES.** The rate-setting experience demonstrates key stakeholders' ability to manipulate regulatory and reimbursement systems to their own advantage. In many cases, the efforts of regulated parties to circumvent or dodge rate-setting rules and requirements were predictable. Other sources of gaming and political influence were unforeseen, however, even by the most sophisticated regulators.

This is important to remember as we enter the brave new world of capitated payments. From our experience with per diem and per case prospective payment, we should expect the new bearers of risk to find creative means to manipulate payment incentives, to use political influence in both formal and informal ways, and to craft the presentation of relevant data and information for their own purposes. We should anticipate robust and confusing debates over the effectiveness and quality of these new payment models that will bewilder policymakers and the public alike. Clear and convincing information still will be hard to

come by, and harder still to understand.

■ **GOVERNMENT CAN MEET ITS OBJECTIVES . . . SOMETIMES.** For a large portion of the twenty-five years that a subset of states maintained aggressive rate-setting systems, they were able to meet multiple goals of reduced cost growth, improved access, and myriad other objectives. We often view regulatory schemes and other public programs according to standards and expectations developed after such initiatives were created and, with the advantage of hindsight, conclude that the program missed the mark. Because most rate-setting systems have now been abandoned, they often are judged as failures.

However, viewed by the standards of the era in which they were created, and seen in the context of the tools that were available and usable at that time, mandatory hospital rate-setting programs were able to leave an overall legacy of effective intervention. In future years, when the shape and effects of the emerging system are more clear, we may yet come to a greater appreciation of the challenges and accomplishments of this health policy epoch.

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*This research was supported by grants from the Health Care Financing Administration and the Michigan Blue Cross and Blue Shield Foundation. The author thanks Catherine McLaughlin, Barry Rabe, John Tierney, William Weissert, Patricia Butler, Daniel Rubin, Melvin Shipp, and Janice Furlong for their helpful comments.*

#### NOTES

1. C. Coelen and D. Sullivan, "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," *Health Care Financing Review* 2, no. 3 (1981): 1-40; and C. Coelen, S. Mennemeyer, and D. Kidder, *Effects of Prospective Reimbursement Programs on Hospital Revenue, Expenses, and Financial Status* (Cambridge, Mass.: Abt Associates, 1986).
2. D. Crozier, "State Rate Setting: A Status Report," *Health Affairs* (Summer 1982): 66-83; and F.A. Sloan, "Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade," *Milbank Memorial Fund Quarterly* 61, no. 2 (1983): 195-217.
3. G.F. Anderson, "All-Payer Ratesetting: Down but Not Out," *Health Care Financing Review* (1991 An-

- nual Supplement): 35–41. As evidence of the decline in health policy interest in rate setting, the five-year 1982–1986 *Health Affairs* index contained a separate category entitled “State Rate Setting” with seventeen references; the 1987–1991 index contained no such category and contained only two rate-setting references, both from 1987.
4. Sloan, “Rate Regulation as a Strategy for Hospital Cost Control.”
  5. See Anderson, “All-Payer Ratesetting,” for an overview of the literature. Coelen et al., *Effects of Prospective Reimbursement Programs on Hospital Revenue, Expenses, and Financial Status* remains the most extensive national survey of all rate-setting programs. For evidence regarding the per capita effects of rate-setting programs, see J.A. Lanning, M.A. Morrisey, and R.L. Ohsfeldt, “Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures,” *Journal of Regulatory Economics* 3, no. 2 (1991): 137–154.
  6. J. McDonough, *Interests and Ideas in Health Policy: The Fate of Hospital Rate Setting in Four States* (Ann Arbor: University of Michigan Press, 1996), chap. 4.
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  8. W.C. Hsiao et al., “Lessons of the New Jersey DRG Payment System,” *Health Affairs* (Summer 1986): 32–43; K.E. Thorpe, “Uncompensated Care Pools and Care to the Uninsured: Lessons from the New York Prospective Hospital Reimbursement Methodology,” *Inquiry* 25, no. 3 (1988): 344–353; and J. Ashby, *Achievement, Access, and Accountability: An Overview of Maryland’s Twenty-two Years of Hospital Rate Regulation, 1971–1993* (Lutherville, Md.: Maryland Hospital Association, 1994).
  9. S.M. Shortell and E.F.X. Hughes, “The Effects of Regulation, Competition, and Ownership on Mortality Rates among Hospital Inpatients,” *The New England Journal of Medicine* (28 April 1988): 1100–1107; and G.L. Gaumer, E. Poggio, and C. Sennett, “Effects of State Prospective Reimbursement Programs on Hospital Mortality,” *Medical Care* 27, no. 7 (1989): 724–736. Both found evidence, although not conclusive, of higher hospital mortality in rate-setting states. For a discussion of these studies’ limitations and problems, see Anderson, “All-Payer Ratesetting.”
  10. For the record, the author participated in these deliberations as a member of the Massachusetts legislature in 1991 and opposed rate-setting de-regulation.
  11. See *Health Care Financing in New York State: A Blueprint for Change* (New York: United Hospital Fund of New York, 1993); J.W. Rodat, *NYPHRM’s Paradox: How New York’s Attempts to Stabilize Hospital Finances Lead to More Uninsured, Increased Health Benefit Restrictions, Reduced Hospital Utilization, and Weakened Hospitals* (Report sponsored by the Life Insurance Council of New York State, Inc. and the State Communities Aid Association, March 1995); S.M. Tully and A.A. Grannis, “Health and Health Care Financing in Transition: Proceedings of the Meeting of the Council on Health Care Financing,” in *Council on Health Care Financing, 1995* (Albany, N.Y.: Council on Health Care Financing, June 1995); and testimony received in conjunction with the Joint Hearing on New York’s health care financing system in transition, sponsored by the Council on Health Care Financing and the Senate Standing Committees on Health and Insurance, Albany, New York, 24 May 1995.
  12. For a discussion of the New Jersey system’s problems, see S.L. Weiner and H.M. Sapolsky, *Hospital Payment Reform: The Case of New Jersey 1980–1994* (Cambridge, Mass.: Massachusetts Institute of Technology, 1994). For a discussion of the New York system, see P.D. Jacobson et al., *State Health Care Reform Initiatives: Progress and Promise* (Santa Monica, Calif.: RAND, September 1994).
  13. Section 1814(e) of the *Social Security Act*, amended in 1987 and 1991.
  14. See *Health Care Reform Act of 1995*, chap. 499, “Acts and Resolves,” signed 25 May 1995.
  15. J.W. Kingdon, *Agendas, Alternatives, and Public Policies* (New York: HarperCollins, 1984), 99–106.
  16. For a discussion of the impact of ERISA on state rate-setting authority, see P. Butler, *Roadblock to Reform: ERISA Implications for State Health Care Initiatives* (Washington: National Governors’ Association, 1994); and National Governors’ Association, “Recent ERISA Developments: Implications of the Travelers Case for State Health Policy Initiatives” (Washington: NGA, 21 July 1995).
  17. *United Wire, Metal & Machine Health and Welfare Fund v Morristown Memorial Hospital*, 95 F.2d 500 (3rd Cir. 1993). Even though the 1992 Federal District Court decision was overturned by the Court of Appeals in 1993, the pool and the rate-setting system had been inalterably affected by the 1992 statutes.