The phenomenon of state rate regulation has a long history, evolving from the efforts of early political reformers to rein in the monopoly powers of public utilities almost 100 years ago. State rate regulation as applied to the health care sphere is of much more recent vintage, deriving, largely from the efforts of a small number of states to stem the Medicaid cost spiral in the early 1970s. These efforts have focused on the control of hospital costs because of the size and growth of these institutions relative to other health care services.

Hospital spending accounts for the largest share of personal health care expenditures—46 percent in 1980, or $99.6 billion. From 1965 through 1980, hospital expenditures grew 616 percent, whereas the Gross National Product increased 280 percent and total personal health care spending rose 508 percent. Similarly, increases in government spending on hospital care have far outstripped growth in tax revenues. In 1980, federal spending on hospitals absorbed 7.3 percent of federal revenues, or $41.3 billion. Fifteen years earlier, the federal government devoted 1.9 percent, or $2.4 billion, of a much smaller budget to hospital care. State and local government spending on hospitals has risen dramatically as well, rising from $3 billion or 1.3 percent of their revenues (excluding federal contributions) in 1965 to $12.9 billion, or 3.5 percent of state and local revenues, in 1980.

What have been the main causes of the increase in hospital spending? Factors external to the health care system—general inflation and population—accounted for 60.7 percent and 6.3 percent, respectively, of total hospital expenditure growth (Table 1). Factors controllable by policies governing the financing and delivery of health care—medical care-specific inflation, and greater volume and sophistication of services—accounted for the remaining 33 percent of the growth in hospital spending. Specifically, inflation in the medical care sector, in excess of general inflation, contributed 1.4 percent of the total increase and greater volume and sophistication of services contributed 31.6 percent.
One key reason for the large increase in the number and sophistication of hospital services is that tax, reimbursement, and social welfare policies have greatly diluted incentives for patients and doctors to balance costs against expected benefits and to choose the least expensive way of achieving a desired outcome. Specifically, employer contributions to employee health insurance premiums are tax free to the employee. By making an extra dollar of health insurance more valuable after taxes than an extra dollar of wages, the tax system has stimulated demand for health insurance whose coverage is so complete that direct employee payments to hospitals are minimal.

Moreover, with enactment of Medicare and Medicaid in 1965, society in effect said to the poor, people over sixty-five, and their doctors, that within a wide range of expenditures they no longer had to worry about the cost of hospital care; regardless of financial capability, government would cover their costs.

Medicare and Medicaid reimbursement has been on the basis of costs; thus, if hospitals lowered their costs, they would actually lose revenues. In sum, the cumulative effect of the tax system, the payment mechanism for health care, and expanded entitlements has been to discourage price competition and the need for patients to search for value as well as quality and convenience.

State Responses To Rising Hospital Expenditures

In striving to curtail the growth of hospital expenditures, states have pursued two basic strategies: capital investment controls through certificate-of-need (CON) programs and hospital price controls, generally referred to as state rate-setting programs. This article will focus on the latter, specifically mandatory control programs where all general acute care hospitals must comply with state rate-setting regulations, and rate control authority is vested in a government agency or government-established independent commission. Based on this definition, seven states have mandatory rate control programs: Connecticut, Maryland, Massachu-

In each of these states, as Prof. Frank A. Sloan, a respected economist, said, “Decisions are made in advance of the year to which they apply. Hospitals are paid according to prospectively determined rates rather than on the basis of actual costs incurred. Finally, hospitals are placed at risk for the differences between revenues and costs.” The types of review vary widely, but all can be arrayed on a spectrum between formula-based rate setting and rate setting based on budget review and negotiation. Most programs use both types of control.

Most rate-setting programs had been authorized and implemented by the mid-seventies. Seven states have established mandatory programs that are still in effect. These states typically have had a higher per capita hospital expenditure than the United States as a whole. The growth rate of hospital spending in these states prior to enactment of mandatory rate setting usually was higher, and Medicaid benefits and eligibility standards tended to be comparatively generous. Two key factors contributing to adoption of hospital rate controls were rising insurance premiums and, most importantly, a financial crisis in the state Medicaid program, caused by hospital expenditures rising much faster than amounts budgeted. In some instances, state hospital associations promoted mandatory rate setting on grounds that state regulation was preferable to federal intervention.

The Case For State Rate Setting

The case for state regulations of hospital rates stands largely on four propositions:

- Hospital expenditures exceed any reasonable measure of corresponding benefits.
- Society in general and government in particular can no longer afford to finance the excess and must take actions whose effects will be felt immediately.
- Government reimbursement on the basis of costs has made hospitals quite inefficient. Thus, when rate setting replaces cost-based reimbursement, large cuts in expenditure growth can be achieved without sacrifice of quality or access by the poor; hospitals will absorb a lower rate of payment increases by improving efficiency.
- While the application of market-based principles is conceptually preferable, implementation of measures to make health care markets more competitive is not feasible in the short run for a number of reasons, say regulation advocates.

The reason most often articulated by such advocates includes the assertion that consumers lack the knowledge and information needed to make sound judgments. But also cited is a belief that society has decided
that there should be equality of access to health care. Thus, requiring patients to bear some of the financial burden of health care decisions made on their behalf and with their consent is considered undesirable, regardless of the cost of those decisions. Limiting freedom of choice to low-cost providers is deemed unacceptable. Regulation advocates also argue that competition takes too long to produce the desired effects. Finally, consumers prefer complete coverage against the risk of hospitalization, so one of the cornerstones of the competition strategy-cost sharing- is not applicable to health care.

Since regulation advocates believe there is a strong need to contain hospital costs, and market approaches in their view are neither practical nor consistent with the egalitarian ideal, they conclude that regulation is unavoidable. The only serious question is what kind. Most settle on general budget constraints established by a state rate-setting organization. Prof. Paul L. Joskow cited the advantages in a recently published book: “We get away from hospital-by-hospital and service-by-service cost and reimbursement regulation by applying a general budget constraint to all hospitals, yielding a regulatory process that is, on the surface, much less complex, arbitrary, and discriminatory. We allow the individual hospitals to decide how their limited resources are to be spent rather than relying on regulators to specify utilization criteria for a laundry list of specific services. . . . We provide incentives to eliminate organizational slack and to introduce process innovations. . . . We not only encourage static efficiency and process innovations, but also constrain the hospitals from expending resources on new product innovations and more intensive use of existing diagnostic and therapeutic techniques. By placing a binding budgetary constraint on hospitals we simply do not allow them to provide the additional services demanded, which are the major source of increasing expenditures, without cutting back someplace else. We force the system to ration the demands for hospital care. . . .”

The Case Against Hospital Rate Regulation

Some analysts who make the case against state rate setting accept the first two propositions of the regulatory strategy, namely, that health care expenditures are excessive, and the nation cannot afford to continue financing the expansion of medical spending at current rates. But, for reasons I will articulate, critics of regulation argue that even if these points are valid, a competition strategy would be not only preferable—given the overriding philosophic tenets of American society which favor free enterprise and individualism—but feasible as well.

Although the health care market is by no means driven by price competition now, it does not follow that government should intervene with “command and control” regulation rather than strive to develop
government-fostered incentives. In fact, as Prof. H.E. Frech III has argued, “The use of market elements and competition in medical care should not be rejected on the basis of the poor performance of the current American system. Rather, medical care has been so closely regulated that the weaknesses of the current medical care system might be taken as evidence against extensive regulation.”

Another argument advanced by competition advocates is that the health care sector lacks the characteristics required for regulation to improve the extent to which patients receive the quality and type of care they want at least cost. There are many providers of health care services. There are a myriad of services, many of which are complex, and every patient’s treatment is different. Thus, while a rate-setting program may control the growth rate of hospital spending, it cannot control what the spending is for. In other words, it cannot control quality.

Rate-setting regulation over the long run will not meet the public’s needs satisfactorily, its critics further contend. The incentives of the regulatory agency are different from the incentives of the public. All the rhetoric about quality notwithstanding, a state rate-setting agency will be judged according to one measure: Has it reduced the growth rate of the state’s budget? Since quality cannot be measured, and regulators have no basis for making cost or quality tradeoffs, quality will be a secondary consideration. Taxpaying patients, on the other hand, value quality of care for themselves very highly. Thus, as Prof. Mark V. Pauly has noted, even if the public representative is doing the best he can, he is likely to be criticized for being at once too lavish with the beneficiaries [of government-financed health programs] and too stingy for taxpayer-consumers.”

State rate setting has little influence on the main cause of unnecessary hospital expenditures, too; namely, the strong incentives created by the financing system toward overutilization. By imposing limits on supply while ignoring the lack of restraints on demand, state rate setting will produce effects that are quite perverse. It creates the illusion of savings when what really is happening is that unconstrained demand continues to be satisfied, but the associated costs are shifted to the nonregulated areas of the health care sector; or they change forms, for example, from money to time; or they are deferred to the future and amplified. The result in the long run is higher health care expenditures than would have occurred without rate setting.

Paradoxically, the more successful a rate-setting program is in controlling costs, the more likely it is to cause a deterioration in quality. The limits imposed by state rate-setting agencies tend to be set in response to government’s desire to reduce its deficits. Since the cost of government’s commitments is greater than what taxpayers are willing to pay, it is unlikely that rates will be adequate to permit hospitals to recover their
full costs. In response, if hospitals operating under a rate-setting program are unable to shift costs, they must choose between reducing the quality of the services they provide or face a serious weakening of their financial condition. Progress toward better health care at less cost depends on rapid innovation in health care delivery. But rate setting inhibits innovation. The rate review process gives established competitors the opportunity to block or delay the implementation of new ideas, thus increasing the risk of innovation and lowering potential reward. Rate setting further dampens entrepreneurial enthusiasm by increasing uncertainty as to how much of the gain from success entrepreneurs would be allowed to keep.

Patients will get better health care value for dollars spent in their behalf not from rate setting, but from measures which collectively do the following: make patients, physicians, and employers more cost conscious; eliminate unnecessary barriers to entry; heighten the risk of loss to providers for failure to improve quality relative to cost; and improve the availability of information useful in comparing providers. In short, patients are better off with more competition.

State rate setting perpetuates incentives to spend as much as possible—regardless of expected benefits—at the same time as it attempts to limit hospital spending. If a hospital's rates are approved by the state, there is no price competition. No hospital is going to risk reducing rates below the approved level only to find that the rate-setting agency denies a subsequent request for increase. Nonetheless, hospitals have to compete for physicians if not for their patients. Lacking the competitive weapon of price, they will turn to nonprice competition, which usually takes the form of services of appeal to physicians. Simply put, the theory that rate setting improves efficiency by permitting hospitals to keep the difference between revenues based on approved rates and costs is undermined by the need to compete for doctors. Hospitals that keep the difference lose physicians.

Joskow has observed: “The literature indicates that... the losses from ‘noncost-minimizing behavior’ [inefficiencies] are small relative to the losses associated with consumption distortions and associated supply-side responses to satisfy excessive demands for care.” This conclusion is consistent with the data in Table 1, which illustrates that greater volume and sophistication of services accounted for almost 32 percent of the increase from 1970 to 1980 in hospital care while factors outside the control of the health care system contributed all but 2 percent of the remainder. These findings suggest that the problem state rate setting is best designed to relieve inefficiency may not be that significant. Meaningful cost savings without commensurate quality reductions must come from a reduced rate in both use of services and introduction of more expensive technology.
State Rate Setting Is Not A Quick Fix

Legislatures, often under intense pressure to produce quick solutions to the problem of spiraling health costs often turn to state rate setting as a speedy remedy. Former Social Security Commissioner Robert M. Ball characterized this dynamic well in a 1974 address to the Institute of Medicine. Ball said: “Direct regulation is very appealing when matters do not seem to be going well. Regulation seems to be the approach that addresses itself most directly to the perceived problem. If prices are “too high,” set rates; if desired services are not available in some area or for some people, fix the responsibility on some institution or organization to see that they are made available; if the quality of service is too low, set standards. Alternatives that involve incentives for performance seem indirect and do not have the appeal of an immediate solution, whereas goals and requirements can be written into law and into regulations giving the appearance, at least, of having solved the problem. We sometimes don’t stop to realize that ordering a man to jump ten feet in the air doesn’t make it possible for him to do so.”

Some states that have moved aggressively to create a rate-setting structure have often experienced onerous, protracted litigation and administrative appeals, thus necessitating major program revisions. In Connecticut, for example, where the state rate-setting authority began approving rate increases in the first year after passage of enabling legislation, total hospital revenues increased faster than allowed increases in per diem revenues. In New Jersey, where there was also immediate implementation of state rate setting, the whole program was subsequently overhauled; a program administered by the hospital association in New Jersey was replaced by a system under the sole jurisdiction of the Department of Health. In those states where the original program has remained largely intact and there has been the least litigation and administrative appeal, the time from legislation enactment to full program implementation has been measured in years. For example, Maryland’s rate setting legislation was enacted in 1971, but the interim system was not implemented until 1974.

In states with mature programs, rate review programs have demonstrated a capacity to reduce hospital spending per admission by a statistically significant amount, but the savings on a per capita basis are less impressive. It is not known whether per capita health care spending growth is reduced. Use of a per capita measure to analyze hospital expenditure trends has the advantage of being more comprehensive than a per admission measure. Thus, a per capita measure gives policymakers insight as to whether increases in hospital admissions are offsetting savings derived from reduced costs per admission.

Michael A. Morrisey and Douglas A. Conrad, two health economists
employed by the American Hospital Association, have reviewed the state of empirical knowledge of hospital rate setting. In an unpublished manuscript dated January, 1982, they said: “Mature rate review programs appear to have produced statistically significant reductions in the rate of increase in the level of hospital costs per admission. However, we do not yet know whether it is maturity of a given program or the recency of the time period being considered [post-1975] that matters for rate review effectiveness.”

Typical findings of the most analytically sophisticated rate-setting studies are reported by Craig Coelen and Daniel Sullivan: “The statistical evidence indicates that some [mandatory prospective payment] programs have been successful in reducing hospital expenditures per patient day, per admission, and per capita. Eight programs . . . have reduced the rate of increase in expenses by two percentage points or more per year and, in some cases, by as much as four to six percentage points.”

The results of the rate-setting studies have been heavily influenced by the New York experience, discussed in detail below. Many states, however, probably would be unwilling to adopt a rate-setting program as stringent as New York’s, which has caused serious cutbacks in hospital capacity. If the New York results are excluded, the effects of rate setting are less impressive. For example, over the period from 1976 to 1980, the annual growth rate of hospital expenditures per capita averaged 3.3 percentage points higher in nonrate-setting states than the growth rate in mandatory states. But the average annual growth rate was only 2.1 percentage points higher in nonmandatory states when New York is excluded (Table 2).

The data shown in Table 2 are not adjusted for state-to-state differences in other factors affecting hospital expenditure growth rates such as different rates of change in price, hospital utilization, population, and age mix. If such adjustments were made, the likely result would be a narrowing of growth rate differences between nonmandatory and mandatory states. Most of the rate-setting states are located in the Northeast, where the cost of living has risen less than in the rest of the country. Specifically, over the period from 1976 to 1980, the cost of living as measured by the Consumer Price Index (CPI) rose 39.2 percent in the Northeast versus an average of 47.2 for the rest of the country.

Another factor which may cause studies of state rate setting to yield results overstating its effectiveness is that, as Joskow notes, “States that initiated rate regulation earliest were those that had high costs per stay and had hospitals offering the most sophisticated hospital care.” For example, per capita hospital expenditures for the seven states with mandatory programs were $250 in 1976 versus $196 for all other states.
Table 2
Hospital Expenditures Per Capita, Annual Percentage Change Trends

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<tbody>
<tr>
<td>Mandatory control states</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All states</td>
<td>10.0</td>
<td>8.4</td>
<td>10.4</td>
<td>13.4</td>
<td>10.5</td>
</tr>
<tr>
<td>All except New York</td>
<td>12.4</td>
<td>9.0</td>
<td>10.9</td>
<td>11.7</td>
<td></td>
</tr>
<tr>
<td>All other states</td>
<td>14.3</td>
<td>12.5</td>
<td>13.1</td>
<td>15.4</td>
<td>13.8</td>
</tr>
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<td>Expenditure growth rate difference, all other states less:</td>
<td></td>
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<td></td>
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<tr>
<td>All mandatory states</td>
<td>4.3</td>
<td>4.1</td>
<td>2.7</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>All mandatory states except New York</td>
<td>1.9</td>
<td>3.5</td>
<td>2.2</td>
<td>.8</td>
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<tr>
<td>Difference in annual expenditure growth rates-all other states less:</td>
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<tr>
<td>All mandatory states</td>
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<tr>
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<td>2.1</td>
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Table 3
Comparison of Operating Margins in Mandatory Control States with Other States and the U.S., 1976-1980

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>0.9%</td>
<td>1.4%</td>
<td>0.8%</td>
<td>1.9%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Maryland</td>
<td>1.0</td>
<td>0.5</td>
<td>1.5</td>
<td>1.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>-0.1</td>
<td>0.1</td>
<td>2.6</td>
<td>4.0</td>
<td>2.3</td>
</tr>
<tr>
<td>New Jersey</td>
<td>0.8</td>
<td>0.0</td>
<td>1.7</td>
<td>0.8</td>
<td>-0.4</td>
</tr>
<tr>
<td>New York</td>
<td>-6.3</td>
<td>-3.3</td>
<td>-2.8</td>
<td>-2.8</td>
<td>-1.2</td>
</tr>
<tr>
<td>Washington</td>
<td>3.2</td>
<td>4.4</td>
<td>5.3</td>
<td>5.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>7.1</td>
<td>3.6</td>
<td>2.3</td>
<td>3.3</td>
<td>2.9</td>
</tr>
<tr>
<td>All mandatory states</td>
<td>-2.0</td>
<td>-0.8</td>
<td>0.0</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>All other states</td>
<td>3.5</td>
<td>3.3</td>
<td>3.6</td>
<td>3.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Total U.S.</td>
<td>2.1</td>
<td>2.3</td>
<td>2.7</td>
<td>3.1</td>
<td>3.8</td>
</tr>
</tbody>
</table>


The comparable figures for 1980 are for mandatory states $373 and all other states $329.

Hospital operating margins are significantly lower in mandatory control states than in other states, and may be inadequate to finance the investment required to keep hospital plants modern. Since access to the capital required to replace, renovate, or modernize existing hospitals depends on their financial health, it may be necessary for operating margins of hospitals in mandatory rate-setting states to improve. Over
the period 1976 through 1980, margins (total net revenues less expenses divided by total net revenue) have ranged from –2 percent to 0.7 percent in states with mandatory state rate setting versus a range of 3.3 percent to 4.7 percent in all other states (Table 3). Since state rate-setting programs differ widely in stringency and impact, a detailed state-by-state analysis is needed to determine whether significant savings can be made without adverse impact on a hospital system’s ability to raise needed capital.

Lessons From Individual States

To determine whether there is a specific type of state rate review program that is most effective in achieving its objectives best, it is necessary to look at individual cases. Three have been chosen: New York, because it has reduced the growth rate of hospital expenditures more than any other state; New Jersey, because its rate-setting formula is by far the most complete and it attempts to account for case mix differences; and Maryland, because its rate-setting program is often considered a model.

New York. New York has the oldest, most stringent hospital rate-setting program. The basic approach is strict application of complicated formulas and trend factors to determine base-level allowable costs per diem and adjustment factors to account for inflation. Although New York has reduced its hospital expenditure growth rate more than any other mandatory rate-setting state, the penalty may be more than other states would be willing to bear. The New York hospital system is in poor financial health. A 1979 survey by the Hospital Association of New York State (the latest available) revealed that between 1974 and 1978, New York voluntary hospitals had to use almost $500 million in hospital reserves to finance current operating losses. At that rate, it would take only fifteen years before the total equity of all 222 voluntary hospitals in New York is consumed.

These operating losses are clearly a trend. Eighty-seven percent of these hospitals suffered losses for at least two of the five years between 1974 and 1978; 41 percent of all New York voluntary hospitals had operating losses in all five years. Although public demand for services and patients served increased during the 1974 to 1978 period, the number of voluntary and public hospitals declined 5.4 percent. What are the implications of these trends for patients? Preliminary estimates show that by 1990, the unmet need for hospital renovation and replacement will amount to 55,559 beds or 66 percent of New York’s acute care bed capacity.
New Jersey. New Jersey is the only state where the diagnosis-related grouping (DRG) concept has been used to set actual payment rates per patient. Hospitals in New Jersey are not unhappy with the new system, which replaced a different form of mandatory rate setting which they found more onerous. New Jersey's hospitals, however, have found the DRG payment system acceptable thus far, not because of the DRG feature, but because the new payment system increased their allowances for such items as depreciation, bad debts, and working capital. Further, the New Jersey payment system does not penalize hospitals if their costs per DRG depart greatly from the average. As a result, the basis for payment ends up being mostly a hospital's own costs, not a standard cost.

The difference between the growth of New Jersey's hospital expenditures per capita and that for nonrate-setting states has been narrowing over time. In 1980, New Jersey’s per capita growth rate in hospital expenditures was the same as that for non-rate-setting states (Table 4). This suggests that the effectiveness of state rate-setting programs in controlling hospital expenditures might diminish over time.

Although the DRG approach has considerable conceptual appeal, its appeal seems to be limited because of practical difficulties. First, reimbursement based on a group average cost per admission with a DRG adjustment does not take into account important but uncontrollable factors affecting an individual hospital’s cost per admission and DRG weights, for example, patient health status. Second, and most important, use of DRG weights to adjust cost per admission creates overwhelming incentives and opportunities to manipulate the reimbursement system to maximize payment. Resolution of this difficulty is essential if the cost containment features of the DRG system are to be effective, but thus far,

| Table 4 |
| Hospital Expenditures Per Capita, Annual Percentage Change Trends |
|----------|----------------|----------------|----------------|----------------|----------------|
| Connecticut | 11.4 | 10.2 | 9.6 | 13.9 | 11.2 |
| Maryland | 10.9 | 12.1 | 14.6 | 15.3 | 13.2 |
| Massachusetts | 13.9 | 7.1 | 9.3 | 15.6 | 11.4 |
| New Jersey | 12.2 | 8.6 | 11.3 | 15.4 | 11.8 |
| New York | 6.9 | 8.0 | 10.6 | 11.1 | 9.1 |
| Washington | 12.7 | 8.4 | 9.3 | 12.3 | 10.9 |
| Wisconsin | 11.2 | 12.3 | 11.3 | 15.1 | 12.5 |
| All mandatory states | 10.0 | 0.4 | 10.4 | 13.4 | 10.5 |
| All mandatory states except New York | 12.4 | 9.0 | 10.9 | 14.6 | 11.7 |
| All other states | 14.3 | 12.5 | 13.1 | 15.4 | 13.8 |

Source: ICF. Inc., based on latest Census Bureau data available as of June 1982.
it seems to be an insuperable barrier. And, there is no evidence yet that a DRG-based payment system produces lasting, meaningful savings.

Maryland. The Health Care Financing Administration’s Office of Research, Demonstrations and Statistics has described Maryland’s rate-setting model as “a quasi-public utility approach to hospital rate regulation, in which rates are set and then adjusted for such things as inflation, volume changes, and pass-through costs. Hospital rate setting in Maryland currently consists of three systems: rate review, inflation adjustment, and the guaranteed inpatient review (GIR) system, which seeks to control the volume of ancillaries and lengths of stay . . . GIR guarantees payment for each case treated by the hospital.”

Hospital expenditures per case rose less in Maryland than in nonrate-setting states from 1976 through 1980. On a per capita basis, however, the difference in expenditure growth rates is smaller. Over the period from 1976 to 1980, hospital expenditures per capita in Maryland rose at a compound annual rate of 13.2 percent versus 13.7 percent for nonrate-setting states. There is no evidence on how the Maryland system affects per capita health care costs.

It is unclear whether Maryland’s rate-setting program will be able in the future to keep hospital spending per capita below what it otherwise would be. Hospital support for Maryland’s program has been conditioned in large part on the perception that the Health Services Cost Review Commission (HSCRC) will not let any hospitals go bankrupt. This creates a dilemma. On the one hand, it is very difficult, perhaps impossible, to contain costs if there is a requirement to guarantee the financial viability of all existing hospitals. On the other hand, the results achieved by the HSCRC to date have been heavily dependent on the hospital system’s willingness to cooperate. The climate may become more adversarial if hospitals become convinced that a key benefit of regulation from their perspective—a government guarantee of survival—has been abandoned.

The capital needs issue is another factor casting doubt on the likelihood of the Maryland program’s ability to contain costs at no sacrifice to quality. Hospital capital requirements in Maryland during the 1980s, based on guidelines developed by the Department of Health and Human Services for determining need, are estimated at $2.8 billion. Unless, however, profit margins improve, the unmet need for renovation and replacement will be $1.3 billion or 4,542 beds (25 percent of total).

Even if the Maryland program were successful over the long run, the question would remain whether the Maryland approach could be successfully transplanted. Maryland has only fifty-one hospitals, a small fraction of them accounting for a disproportionate share of total expenditures, and HSCRC’s success has been due in no small measure to extensive
informal negotiations with individual hospitals. This personal process may not be administratively feasible in states with large hospital systems. Finally, the Maryland rate-setting program has a reputation for being exceptionally well managed. It may be unreasonable to expect most other states to attract comparable regulators.

Recent Developments

No mandatory rate-setting programs have been implemented since 1976. Also, Colorado’s program has been repealed, and Connecticut’s and Washington’s mandatory rate-setting programs have been scaled down. In Connecticut, the system for screening hospitals has been modified so that most hospitals will be able to avoid undergoing an annual budget review. Washington, experiencing deficits in its Medicaid program as the result of an increased number of eligibles, stopped Medicaid’s participation, and the federal government followed suit by withdrawing its waiver of the requirement that Medicare pay hospitals on the basis of costs. Both programs reverted to cost-based reimbursement.

Conversely, commercial insurance companies, who have been assuming a steadily increasing amount of the uncompensated costs of hospital care for Medicare beneficiaries, have embarked upon a nationwide advertising campaign in support of state rate setting. Their theory seems to be that state rate-setting programs—by putting all payers on the same payment system—will increase the share of total Medicare costs paid by the federal government. In view of the projections of large and increasing federal budget deficits, there is some question whether this is a realistic assumption.

The evidence is compelling that Medicare’s costs would be higher in the years immediately following a switch from cost-based reimbursement to payment on the basis of rates. For example, the waiver of Medicare’s requirement that payments to hospitals be based on their costs became effective as of July 1, 1977. Over the from 1976 to 1980, total Medicare spending per enrollee grew 80 percent in Maryland versus 74.5 percent for the rest of the United States. The corresponding growth rates for inpatient benefits were 72.6 percent and 70.3 percent, respectively. Had total Maryland Medicare spending grown at the same rate as spending in all areas less Maryland, Medicare expenditures in Maryland from 1976 to 1980 would have been $104 million less than they actually were. Inpatient hospital spending over the same period would have been $42 million lower.

The Policymaker’s Dilemma

There is a growing, if reluctant, acknowledgment in industry circles
that maintaining the status quo of America’s health care enterprise will be impossible. There also is general agreement that the broad policy choice facing the health sphere is not strictly between models based on regulation or competition principles but rather which of these approaches should be emphasized in the ultimate blending. In deciding the appropriate balance, and not having the luxury of awaiting more data, policymakers face a dilemma: whether to opt for state rate setting or consider more competitive approaches.

State rate setting has considerable political advantage working on its behalf. As Ball suggests, it gives the impression of dealing directly with the problem. And further to its political advantage, it does not confront patients with the need to consider cost. It is at least a known quantity. And, like any price control program, it can demonstrate favorable results for a while. The extent of the savings will depend upon the measure. The more limited the measure (e.g., hospital costs per day), the greater will be the savings and vice versa (e.g., hospital costs per capita).

Rate setting, however, is not free from risk, particularly of political risk. For rate setting to work, power over allocation of health care resources is centralized within the public sector. Every decision involving a hospital becomes a political decision, as New York’s situation bears witness. Since no one usually favors a reduction in the level or access of services already available, cutbacks or even denials for upgrading—as evidenced by the history of the certificate-of-need program—become difficult at best. Yet, without restraints on utilization, long-term significant savings are unlikely to be realized. Thus, while state rate setting can defer the emergence of intense political conflict, it certainly cannot avoid it.

In sum, state rate setting obscures and delays public recognition of the necessity to choose between cost and quality. But since resources are limited, it does not eliminate the need for someone to choose how much should be spent and how the benefits should be distributed. Hospital rate regulation merely transfers rationing authority from patients and doctors to a small group of regulators. In sharp contrast, the competition strategy, where the consumer would reign supreme, would make explicit and immediately visible the need for patients to balance costs against expected benefits. It would also force doctors and hospitals to work harder to earn their revenues by placing them at economic risk for rendering unnecessary service.
NOTES

1. Author’s calculations. Federal and state expenditure data are from the Statistical Abstract of the United States, 1980, page 287, Table 480; and page 296, Table 492, both updated through 1980 via oral communication with the Bureau of Census. Health and hospital spending data are from “National Health Expenditures, 1980,” Health Care Financing Review, September, 1981, Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, page 48, Table 7A; and page 53, Table 7F. The revenue data are available on a fiscal year basis, but hospital data are presented for calendar years. Thus, for both 1965 and 1980, hospital spending as a percent of government revenue will be slightly overstated. The overstatement is not material.


3. Frank A. Sloan, “Regulation and the Rising Cost of Hospital Care,” (Manuscript reporting research supported in part by Grant #18-P-9709014 from the Health Care Financing Administration to Vanderbilt University, 1981), p. 6.


13. Preliminary estimates from an analysis prepared for the Federation of American Hospitals by ICF, Inc. The projections are based on a model originally developed under contract to the National Center for Health Services Research (Contract No. 223-79-3002).


15. See footnote 14.