

Point-Counterpoint

# **Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency**

**Mark Pauly**

**Robert Town**

University of Pennsylvania

## **Introduction**

Medical services, like most services (haircuts, airfares), sell for different prices in the same local market. In contrast to gasoline, where the product is homogeneous and competition prevails, quality is uniform, and consumers are fairly efficient searchers, the medical care market would probably display price variation even if its products were not sometimes a matter of life and death and almost always covered by some third-party payer that insulates consumers from knowledge of and concern about prices. Add these special considerations and it is no surprise that we see different prices charged by or accepted by different hospitals or doctors for what appear to be similar products, and even different prices charged by the same firms to different buyers (usually insurers) for apparently the same product.

This untidiness causes some concern to economists, but the possibility that it is associated with high levels (or higher-than-they-ought-to-be levels) of medical spending make it of even greater concern to policy makers, politicians, and even some voters. Establishing an entity that makes sure everyone pays the same price removes the variation (or determines the appropriate level of variation), which may matter to those (usually not economists) who are concerned about equity. More importantly, the hope springs eternal that the entity that reduces variation can also get this uniform price down to the lower end of the range of prices that would

otherwise prevail, thus saving the average buyer some money but in such a way that there is no sacrifice in quality of care or access to care.

Given the disarray of typical medical markets, the attractiveness of this proposition at various times was enough to persuade more than thirty states to institute various kinds of single-payer systems for hospital care. (None have ever done so for physician services.) These systems never were perfectly uniform “single-price” homogeneous-good models that would replicate ideal competitive markets; they still often allow prices to vary across sellers (but in an approved and controlled way), require every buyer to pay the same prices for the same things at a given seller, but cannot control quality or sophistication or patient friendliness of care. Over the decades, for reasons about which we will speculate, all have abandoned this model except for two states, Maryland and West Virginia (McDonough 1997). Only Maryland uses this system for Medicare and Medicaid (which make up more than half of hospital spending). What is also hard to prove but generally believed is that the administration of rate setting in Maryland has been exceptionally skilled and that the other states that abandoned this process did so in part because of lack of confidence (and evidence) that they had continued or could continue to do nearly as well. Furthermore, Maryland market setting is unique, with few states having comparable environments. That is, the ability of the Maryland system to survive is probably best viewed as a difficult-to-replicate anomaly rather than a model that can be readily adopted by other states.

Both the unsatisfactory performance of markets and the past failures of limited regulatory systems are certainly cautionary. No doubt we can learn from the past, but simply stating that we need to implement the optimal rate-setting body seems to assume away some fundamental problems. To be clear, setting the “right” prices for thousands of often complex and evolving services is extremely challenging. We see no evidence that our political environment has sufficiently moved up the evolutionary chain since the 1970s to now broadly put into place the optimal regulatory structure (one that is accurate, evidence based, and insulated from political and financial pressures) that would allow it to better price hospital services than our current imperfect system.

Of course, all-payer rate setting is used in several OECD countries with at least some success. While tempting, attributing cross-country differences in health care expenditures and experience to a single institutional difference is risky; those countries typically have much more heavily regulated tax-financed insurance systems with limits on insurer competi-

tion. It is riskier still to infer that if the United States implemented such a scheme the outcomes would be comparable to the OECD experience. The differences between the United States and the OECD health care systems extend well beyond the hospital payment system. Understanding the impact of such a dramatic change requires a much more holistic view of the health care system and necessitates the assessment of a broad array of provider and patient incentives. Even in the OECD, health systems are moving toward more market-based environments, suggesting that all is not well with these regulated hospital price approaches. The Netherlands, in fact, has moved away from a single all-payer price system to one in which insurers negotiate with hospitals over prices (Halbersma et al. 2011).

### **What Did It Do, Really?**

During the time since the system's institution in 1976, hospital cost per case—the price the system in Maryland targets and controls—grew much less rapidly in Maryland than nationwide. While anticipated regression to the mean might account for some of the shift in Maryland's relative rank, there is little doubt that its regulation succeeded in limiting what it was supposed to limit. Regulation was technically skillful and the regulators were politically deft; the process was transparent, rigorous, and unmanipulable, and the voting population was willing.

But that is not the whole story, or even the most important part of the story. Both hospital cost per capita and total personal health spending per capita have grown more rapidly in Maryland than nationwide and more rapidly than in neighboring states in the mideast region (New York, New Jersey, Pennsylvania, Delaware, and the District of Columbia in addition to Maryland).

Table 1 shows levels and changes over time in these measures in Maryland relative to neighboring states and the country since 1991, the earliest year with reliable data. So the system appears to be far from a success in holding down total health spending per capita, which is the primary object of policy concern. It is also worth noting that Medicare still pays higher prices to hospitals in Maryland than it does nationwide, to the annual tune of about \$500 million (or about 5 percent of hospital revenue), something that has probably helped keep hospitals pleased with the system (Zhang 2009).

Table 2 shows that Medicare's payments per enrollee in Maryland remain well above the national average, despite a slightly slower growth

**Table 1** Average Annual Percentage Growth (1991–2009)

Personal Health Spending per Capita	
United States	5.3%
Maryland	5.7%
Mideast Region	5.4%
Hospital Spending per Capita	
United States	4.7%
Maryland	5.1%
Mideast Region	4.4%

*Source:* Centers for Medicare and Medicaid Services

**Table 2** Medicare Average Annual Percentage Growth (1991–2009) and Medicare Spending per Enrollee (2009)

	Growth	Spending per Enrollee
United States	6.3%	\$10,365
Maryland	6.0%	\$11,157
Mideast Region	6.0%	\$11,297

*Source:* Centers for Medicare and Medicaid Services

rate than the nation. (Interestingly, Maryland's rehospitalization rate for Medicare patients is the second highest in the country [Jencks, Williams, and Coleman 2011].) Maryland's ability to retain its waiver to have Medicare pay hospitals differently has come under threat as its payment for this population under its special system has remained high relative to what Medicare would have paid under the prospective payment system. Without this US taxpayer subsidy for the Maryland single-payer system, it is unlikely that it would have achieved as much popularity.

Maryland did try to control volume during part of this period by approving charges based on the assumption that the marginal cost of incremental admissions was below average (which meant that, other things being equal, approved charges per admission would decline when admissions increased) for part of the period. However, the state abandoned this procedure in 2000 based on political pressures associated with the short-run success of managed care in controlling admission rates and hospital days. It subsequently experienced a substantially above-average growth

in admissions until 2007, when it reimposed the rule, and it has since had admission growth close to the national average.

The argument usually then made by supporters of the Maryland system is that the hospital payment commission can control only what hospitals do, whereas both admission rates and use of care outside hospitals are up to physicians (Murray 2009). Why physicians in Maryland apparently were less well behaved than those nationwide is not explained. The thought that limiting the resources available per admission may at the margin cause some substitution of multiple admissions or outpatient care has not been taken into account. Moreover, supporters of the system also cite its performance in increasing access to care; by this they mean accessed primarily by the uninsured and those on Medicaid, but some of the increase in access may paradoxically have led to higher total spending, as the uncompensated care percentage in Maryland grew from 4 to 8 percent of total hospital revenues.

The calculations in the literature of cost savings under this system (Murray 2009; Zhang 2009) thus fail to fully take into account the growth rate of the quantity of hospital care in Maryland; they are obtained by taking the difference in unit payments and multiplying by the actual number of admissions. In effect they assume that growth in admission or admission equivalents (on the outpatient side) was largely unaffected by hospital rate regulation, something that remains to be proved.

That hospitals, insurers, and other special interest groups in Maryland are generally supportive of the system is in large part a testimonial to its administration. It may also reflect the fact that because of rate regulation all these industries are protected from risk, and because of the Medicare subsidy they are protected against losses. Some evidence for this is that the average accounting profit margins in Maryland hospitals appear to be considerably below the national average, and the advocates of the Maryland system attribute this to less risk. However, the primary effect of greater risk should be to reduce profit margins for some hospitals while increasing them for others, so this argument is not completely compelling; the assumption must be that higher risk must be offset by higher expected profit margins, plausible perhaps for investor-owned firms but not for nonprofits that do not have equity owners that they must please. More plausibly, since the primary use of hospital profits is not to build up cash reserves against risk but instead involves risky investment in new technology that will ultimately raise costs, often for competitive reasons, the main advantage of rate regulation that limits both profits and cost is

probably a more peaceful life for hospital managements, even at lower profit margins. Little wonder they are grateful.

### **The Market Alternative**

We stipulate that all-payers hospital rate regulation in Maryland (but nowhere else in the United States) was able to both sustain political support and provide a reasonable (if not necessarily a lower than average) rate of growth in health care spending, compared with the alternative of the insurance market that prevails today in the rest of the country, with a mix of large price-setting public payers and competing private insurance firms of varying (but usually limited) market power relative to hospitals.

The current system (outside Maryland) could indeed be problematic in markets similar to that in Maryland, where there are one or two dominant hospital systems but no single dominant private insurer. This characterizes the bulk of the population in Maryland: Johns Hopkins and the University of Maryland dominate the market in Baltimore and environs where most of the state's population lives. It is probably the case that, absent regulation, this system would have led to higher prices (though not necessarily more rapidly growing prices) than did the all-payers system. But the current market might work as well as or better than that in Maryland in other states with other kinds of markets. In particular, states that have the possibility of having competitive hospital markets would probably experience smaller or no gain from an all-payers system than has Maryland, assuming that hospital competition also results in lower or less rapidly growing prices.

The potential of gains from more competition has been central to economic analysis of the undesirability of hospital mergers and other changes that reduce hospital competition. Maryland may have had little or no choice but to convert its hospital system to a regulated public utility, complete with *de facto* rate of return regulation, but other states, those with more and larger local markets where real competition might occur or those with no dominant delivery systems, do have other options. The literature is pretty clear: when hospital competition is vigorous, hospital prices are significantly lower, and this was particularly true during the peak of the managed care movement (Gaynor and Town 2012).

Unfortunately, the hospital merger wave of the 1990s left many cities (both large and small) with highly concentrated hospital markets. In addition, the withering of managed care and the increase in health insurance concentration is leaving much of the country with bilateral hospital-

insurance oligopolies. In this situation, prices will almost surely be in the limbotic region between perfectly competitive ideal and monopolistic levels. The promise of market forces putting the brakes on hospital cost growth is thus at least partly undermined by the long-run incentives that hospital systems face to consolidate and secure market power. It is also undermined by the tax exclusion for group insurance, which attenuates buyer incentives to seek lower prices.

The period from the 1980s to the 1990s was a dark one for antitrust enforcement in the hospital industry. The Department of Justice and the Federal Trade Commission (FTC) lost eight consecutive hospital merger cases. However, the report of the death of antitrust enforcement toward hospitals is premature. The FTC won its retrospective merger case against Evanston Northwestern Hospital and more recently successfully litigated its suit blocking ProMedica Health System's merger with St. Luke's Hospital in Toledo, Ohio. While mergers during the 1990s left many hospital markets consolidated, there is good reason to believe that the trend toward greater hospital market consolidation has been broken (or at least attenuated) by the threat of real and effective antitrust enforcement.

The most troubling economic aspect of hospital pricing and spending in market settings is cost shifting, the amount of price variation at any point in time combined with the belief that it can be exacerbated over time (Ginsberg 2010). The general economic consensus is that cost shifting can occur only if hospitals were initially setting prices below the profit-maximizing discriminatory price in earlier periods, and the general view is that shifting is diminishing in importance as prices rise on the private side closer to that level. A somewhat different twist on the story is to assume that hospitals do discriminate on price among private insurers but that much of the would-be profit from this exercise is then absorbed by Medicaid and Medicare in the administrative prices they set. They do so in such a way that the overall profit margin is just enough to keep hospitals healthy enough to remain in business. Under this latter arrangement, high hospital (actual) profit margins for private insurance are what causes public payers to choose to pay less relative to costs; were public payers (contrary to how they actually behave) suddenly to decide to pay more, that would not cause private prices to fall.

There is still a puzzle here, we must admit. Low market power on the parts of buyers of hospital care can make hospitals that are interested in profits or in what they can do with profits charge higher prices than if there were more buyer market power. But the only way hospitals can have an ability to charge ever higher prices is if their market power is continually

increasing over time relative to buyers. While the competitive positions of hospitals relative to insurers ebb and flow over time and vary across markets, we are aware of no theory and no evidence, even circumstantial, that it is ever increasing. Moreover, it is important to remember that lower prices should not be society's objective; a buyers' cartel can lower prices (even below what would have been the competitive level), but that does not lead to an efficient outcome. And the outcome of bilateral bargaining of oligopolists versus oligopsonists can lead to an even worse situation (Pauly 1987). The key question is which arrangement gets quantity and quality of output to settle at the efficient level (where marginal benefit to consumers equals marginal cost to producers), and there is no easy way to handicap which balance of power will do that. Only perfect competition on both sides gets the theoretical gold medal, but if we must be or choose to be away from that outcome, we are lost in speculation about the second best.

Whatever the story, the average aggregate amount of public-private cross subsidization presumably remains the same under an all-payers arrangement; what markets do is distribute the "tax" on private insurance more unevenly than regulators do. The main point is that this discussion has almost nothing to do with spending growth per se, other than implying that if Medicare and Medicaid try to save taxpayers money by underpaying hospitals, those same taxpayers will still pay—in a less efficient and equitable way—through cost shifting. That is, the ideal would be for Medicare and Medicaid to step up, ask the taxpayers to pay enough additional fair and efficient taxes so they could cover the costs of their clients, and then use hospital competition to hold down private prices and profit margins.

### **The All-Regulation Alternative**

Supporters of the steps taken in Maryland admit that despite some success in controlling its regulatory target, the regulation in that state has been unable to get its arms around total spending or total spending growth. But they believe this is not proof that regulation has not been tried and failed; it is because regulation has not yet really been tried in its full and most powerful form. In skilled hands and with enough patience, they think, hospital rate and revenue regulation can be made to work well over the long term, even if that regulation does not perform so well at any point in time. (The same comment might be made about some true believers in markets, we should note.) Maryland's regulation comes closest to making



the case for that belief; perhaps the periods of quantity growth and the politics that permitted them were only temporary and aberrant and would be avoided in ideal long-term regulation. Now as always some states have aspirations about controlling total spending and are optimistic about their plans to do so. However, we do not think there is compelling evidence that state governments in the United States have been able to do this in the past. Calling something “unprecedented” is not the same as calling it hopeless, but it does imply a soft evidence base.

It is important to note that controlling the level and growth in the quantity and quality of care, rather than just its unit price, is likely to face more severe administrative and political difficulties. Consumers generally are not alarmed at price controls in health care (despite attempts of provider groups to stir them up), in part because insurance insulates them from those prices and in part because long-run effects of price controls like shortages are often not easily linked to (or anticipated as effects of) controls on unit prices. But consumers (and voters) do experience every day the benefits from being able to get medical care when they want it and having access to new and beneficial technology, and they are deeply skeptical of political attempts to control total spending by limiting what they can get or spend (or have spent on their behalf). Consumers fundamentally want to continue to have the freedom to spend what they think is ultimately their own money on their own medical and hospital care, whatever that does to socially endorsed goals of cost containment. Capping spending growth is the feature of the Clinton health plan that actors were discussing at their kitchen table in one of the most successful adversarial commercials, and the arguments for the most recent health reform shied away from even hints of rationing or limits on quantity whenever such issues were raised. The pressures of ever-rising spending on more slowly growing household incomes and budgets may reverse this political reality, and as noted some states are hoping they can get total spending under control by more magical methods designed to laser in on waste and unnecessary care. But capping either total quantity and quality or total budget growth is probably the most unprecedented approach of all.

### **Any Chances of a Brighter Day?**

Let us return to the market alternative. That the market nirvana will rarely be approached means that we are bound to have imperfect performance (relative to the ideal) in most unregulated markets. But even Maryland's story gives us little reason to predict that outcomes will be necessarily

(or even usually) better overall in regulated all-payers markets in states other than Maryland. Regulators in real life do not know what efficient costs ought to be, are subject to political pressure and industry capture, and are especially unskilled at dealing with new technology and changing markets. And, to judge from the past, the average garden-variety state regulator will be neither as skillful nor as dedicated as those in Maryland.

With a plague on both kinds of houses not constituting useful advice to policy makers, what else can we say to them beyond “Do what you want to do, and good luck”? Maryland was the best of the best when it came to hospital unit price regulation, and even its system so far has been unable to control what really matters—total spending growth. Other states with less favorable markets, less favorable political settings, or less skilled administrators may well be unable to replicate even what Maryland did, much less bite off total revenue containment.

We may thus be better off by advocating leaving hospital regulation aside and concentrating necessarily limited political attention and clout on what drives spending growth, rather than on what causes the messengers to deliver the bad news. The tax exclusion, subsidies, and patents that increase the amount and prices of cost-increasing technical change, vigorous antitrust enforcement, and the ever elusive leadership and climate change that could reduce variations in medical practice might all be better points of attention than trying to control a price or profit margin, which is in many ways an effect rather than a cause of spending growth. At most, regulation could be limited to markets unable to be workably competitive; even here the case would have to be made that the skill and political climate is as favorable to good regulation as it has been in Maryland.

## References

- Centers for Medicare and Medicaid Services. Various years. Health Expenditures by State of Residence: Summary Tables, 1991–2009. Tables: Total All Payers per Capita State Estimates by State of Residence—Personal Health Care (Dollars); Total All Payers per Capita State Estimates by State of Residence—Hospital Care (Dollars); Medicare per Enrollee State Estimates by State of Residence—Personal Health Care (Dollars). [www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf](http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf) (accessed January 19, 2012).
- Gaynor, M., and R. Town. 2012. Competition in Health Care Markets. In *Handbook of Health Economics*, vol. 2, ed. T. McGuire, M. Pauly, and P. Pita Barros, 499–637. Amsterdam: Elsevier.

- Ginsberg, P. 2010. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. HSC Research Brief No. 16. Washington, DC: Center for Studying Health System Change.
- Halbersma, R. S., M. C. Mikkers, E. Motchenkova, and I. Seinen. 2011. Market Structure and Hospital-Insurer Bargaining in the Netherlands. *European Journal of Health Economics* 12 (6):589–603.
- Jencks, S. F., M. V. Williams, and E. A. Coleman. 2011. Rehospitalization among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine* 360 (14):1418–1428.
- McDonough, J. E. 1997. Tracking the Demise of State Hospital Rate Setting. *Health Affairs* 16 (1):142–149.
- Murray, R. 2009. Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience. *Health Affairs* 28 (5):1395–1405.
- Pauly, M. V. 1987. Monopsony Power in Health Insurance: Thinking Straight while Standing on Your Head. *Journal of Health Economics* 6 (1):73–81.
- Zhang, J. 2009. Maryland Reins in Hospital Costs by Setting Rates. *Wall Street Journal*, September 14.

Copyright of Journal of Health Politics, Policy & Law is the property of Duke University Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.