State Hospital Cost Containment: An Analysis of Legislative Initiatives

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As a result of the success of various state efforts at containing hospital cost inflation and the encouragement such efforts have received in recent federal legislation directed at reducing Medicare costs,[1] a second wave of state initiatives directed at regulating hospital revenues appears to be breaking out in legislatures across the land. In 1983, three states enacted mandatory hospital rate-setting legislation.[2] In 1984, at least ten legislatures considered similar proposals. It has been suggested that in the next few years over half of the states will have adopted such measures.[3]

Observation of several recent legislative campaigns suggests an interesting similarity of parties, interests, tactics, arguments, and outcomes common to such efforts. Unlike many areas of public action where a small number of interests are contesting for resource control, any change involving hospitals has an immediate impact on a large number of groups. This Article attempts to identify the parties interested in state efforts to reform hospital financing mechanisms. It also describes the likely arguments and positions of each party, the dynamics of the various legislative tactics, and the probable outcomes.

This analysis is based on the author's experience and observations from 1980 to 1985 in eighteen states where hospital rate setting has been either: 1) successfully established by legislation, 2) enacted but not given life as an operating program, 3) considered by the legislature but not enacted, or 4) the focus of formal study by a gubernatorial or legislative task force or work group.[4] Because hospital rate setting has been the

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[1]Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, §§ 601 *et seq.*, 97 Stat. 65 (codified as amended at 42 U.S.C. §§ 1395ww(b), (d) (1982 & Supp. 1985)).

[2]The three states were: Maine, ME. REV. STAT. ANN. tit. 22, § 381 (West Supp. 1986); Maryland, MD. HEALTH GEN. CODE ANN. § 19-209 (Supp. 1986); and Wisconsin, WIS. STAT. ANN. §§ 54.01 *et seq.* (West Supp. 1986).

[3]*See generally* INTERGOVERNMENTAL HEALTH POLICY PROJECT, STATE HEALTH NOTES (D. Merritt ed. March 1985).

[4]*See* AM. HOSP. ASS'N, STATE RATE-SETTING LEGISLATION: LEGAL ISSUES IN THE NEGOTIATION AND IMPLEMENTATION OF A STATUTE (1984); INTERGOVERNMENTAL HEALTH POLICY PROJECT, THE STATUS OF MAJOR STATE POLICIES AFFECTING HOSPITAL CAPITAL INVESTMENT (1984); NAT'L CONFERENCE OF STATE LEGISLATURES, HEALTH CARE COST CONTAINMENT LEGISLATION: 1983 LEGISLATIVE UPDATE FIFTY STATES (1983); NAT'L CONFERENCE OF STATE LEGISLATURES, 1984 STATE HEALTH CARE COST CONTAINMENT LEGISLATION (1984);

object of legislative action or governmental study in approximately twenty-three states,[5] the experience reported here, while representative, is not comprehensive.

I. Background on State Legislation

A. Forces for Reform

It is clear that the nation is struggling with the problem of unacceptable hospital costs. Evidence suggests that the health care delivery system is operating inefficiently.[6] Since the passage of the Medicare diagnostic-payment system in 1983,[7] falling hospital occupancy throughout the nation suggests that hospitals have in fact been overutilized.[8] Moreover, the large increase in the number of physicians entering the system[9] and the increasing age of the population[10] add a sense of urgency to the search for some means of reducing, or at least holding in check, the growth of the health care enterprise. Largely because hospitals are the most visible entity in the delivery system and have had the fastest relative increase in unit prices and absolute budgets,[11] they have been singled out as the object of public and private policy aimed at reducing overall health expenditures.

Partly as a response to the entry of government as a significant

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Schramm, Wren & Biles, *Controlling Hospital Cost Inflation: New Perspectives on State Rate Setting*, 5 Health Aff. 22, 23 (1986).

[5]*See supra* note 4 and accompanying text. Previous model state hospital legislation has been the basis for several legislative proposals and underlies the recently enacted West Virginia legislation. Schramm, *A State-Based Approach to Hospital Cost Containment*, 18 Harv. J. on Legis. 603, 658-78 (1981).

[6]*See, e.g.*, Dep't of Health & Human Services, Hospital Prospective Payment for Medicare: Report to Congress Required by the Tax Equity and Fiscal Responsibility Act of 1982 i-iii (1982); Dep't of Health & Human Services, Office of Ass't Secretary for Planning & Evaluation, Hospital Capital Expenses, A Medicare Payment Strategy for the Future: Report to Congress 1-33 (1986); Prospective Payment Assessment Comm'n, Medicare Prospective Payment and the American Health Care System: Report to the Congress 9-11 (1986) [hereinafter ProPAC Report on the American Health Care System].

[7]Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, §§ 601 *et seq.*, 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww(d) (1982 & Supp. 1985)).

[8]ProPAC Report on the American Health Care System, *supra* note 6, at 19-20.

[9]*See generally* The Coming Physician Surplus (E. Ginzberg & M. Ostow eds. 1984).

[10]*See generally* Fuchs, *"Though Much is Taken": Reflections on Aging, Health, and Medical Care*, 62 Milbank Mem. Fund Q. 143 (1984).

[11]Gornik, Greenberg, Eggers & Dobson, *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, Health Care Fin. Rev. 13, 43 (Supp. 1985) [hereinafter *Twenty Years of Medicare and Medicaid*].

payer of health care costs through Medicare and Medicaid, hospital prices have grown at a rate outstripping that of all other goods and services in the economy.[12] Consequently, it is not surprising that government has been the most active party attempting to reduce overall hospital cost inflation. Government interest is founded on two bases: government is attempting to react to the complaints of citizens about a politically sensitive issue, and government, as a payer itself through Medicare and Medicaid, is directly affected in its own budgets by cost inflation in hospital services.

Governmental approaches to the problem of inflation in certain markets can generally be characterized as regulatory in nature, i.e., a public agency typically becomes the mechanism by which prices are determined.[13] However, in the case of hospital costs, government has actively sought non-regulatory answers as well, including the establishment of alternative providers of care such as health maintenance organizations (HMO's) and the encouragement of financing mechanisms that result in more rational economic choices by consumers. The latter approach stimulates insurers to increase the presence of coinsurance and deductibles and to pay for second opinions in order to reduce the incidence of unnecessary surgery.[14]

Recently, however, concern with reducing costs in health and hospital care has grown so widespread that a larger number of private parties have taken an active role in influencing hospital prices. These include employers, unions, and health insurance companies. In response, providers, including hospitals and physicians, have unsuccessfully attempted voluntary price restraint as one possible solution.[15]

While there is widespread concern that hospital prices are rising too rapidly, few agree on how the problem should be attacked. However, several goals seem to be uniform objectives. The first is reducing the rate of increase in hospital cost inflation.[16] This has been the most widely accepted policy objective, largely because hospital prices have been rising faster than prices for other goods and services.[17]

In more recent years a second goal has become important, namely, reducing absolute levels of spending on health care. This objective began

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[12]*See, e.g.*, Levits, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1984, at 1, 8 [hereinafter *National Health Expenditures, 1984*]; PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATIONS TO THE SECRETARY 12-13 (1985) [hereinafter PROPAC REPORT TO THE SECRETARY, 1985].

[13]*See generally* S. BREYER, REGULATION AND ITS REFORM 15-35 (1982).

[14]*See* PROPAC REPORT TO THE SECRETARY, 1985, *supra* note 12, at 13.

[15]*See, e.g.*, AM. HOSP. ASS'N, 1978-79 GOALS OF THE VOLUNTARY EFFORT (1979).

[16]Biles, Schramm & Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 N. ENG. J. MED. 663 (1980).

[17]*Twenty Years of Medicare and Medicaid*, *supra* note 11, at 16-17.

to emerge with the recession of the early 1980's and with the immense growth of the federal deficit.[18] Related to reducing absolute levels of spending is the goal of reducing per capita spending on health care.[19] The emergence of these goals suggests that merely to reduce the rate of change in hospital prices, or to cut back levels of spending, is to avoid the issue of the drift of real wealth into the health care sector from other areas of social enterprise. The twofold growth of GNP shares consumed by the health sector in the post-Medicare era is evidence that wealth drift is the operative issue of concern.[20]

Therefore, the objective of those concerned over rising health care costs is some effective solution to the problem. While many have argued that competitive or market-based solutions offer the best hope of reducing the health care cost problem[21]—and, to be sure, increased competition in health care markets in the next few years will be observed — others believe it is inevitable that government will be the prime mover in restructuring the reimbursement system.[22] Government may act to reduce its own budget exposure and it may act for broader motives such as ensuring an orderly and politically acceptable allocation system.

B. The Road to Legislation—Four Premises of State Regulation

The first premise of government efforts to reduce costs is that legislative intervention and guidance are necessary if any system-wide change is to come about. For over a decade, hospital costs have been termed a serious, even critical, problem by many private interests. However, until very recently, there has been no evidence of any consensus, let alone action, among private sector actors. While there are increasing signs that some employers have taken an active interest in reducing health care costs,[23] it seems likely that government action will be necessary

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[18]The deficit in the federal budget increased from $59.6 billion in fiscal year 1980 to an estimated $207.7 billion in fiscal year 1983. OFFICE OF MANAGEMENT & BUDGET, FISCAL YEAR 1982, BUDGET REVISIONS, March 1981, at 11; OFFICE OF MANAGEMENT & BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1984 M11 (1983).

[19]*See National Health Expenditures, 1984*, *supra* note 12, at 15-19; *see also* M. ZUBKOFF, I. RUSKIN & R. HANFT, HOSPITAL COST CONTAINMENT 579-85 (1977).

[20]Schramm, *Can We Solve the Hospital-Cost Problem in Our Democracy?*, 311 NEW ENG. J. MED. 729 (1984).

[21]*See generally* A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF HEALTH CARE 70-92 (1980).

[22]*See generally* Davis & Rowland, *Medicare Reform Options*, in RESHAPING HEALTH CARE FOR THE ELDERLY: RECOMMENDATIONS FOR NATIONAL POLICY (C. Eisdorfer ed., forthcoming).

[23]*See, e.g.*, *The Corporate Rx for Medical Costs: A Push for Revolutionary Changes in the Health Care Industry*, BUSINESS WEEK, Oct. 15, 1984, at 138-41.

to stimulate and channel change and to ensure that whatever change occurs serves the public interest.

The second premise is that the forum of policy change will be the legislature. Over the last ten years, the executive branch has not developed a solution acceptable to a sufficiently large coalition of interests; consequently, the executive branch has forfeited control of the health care cost issue to the legislature. Issues that do not yield to consensual solution within the executive branch must be solved, if at all, in the legislative branch. Moreover, the legislature, because it effectively controls the spending power and is responsible for taxing, has been required to act on health care costs from a budget perspective. Clearly, at the federal level, it was Congress that created the Omnibus Reconciliation Act in 1981, changing Medicaid programs substantially,[24] that fashioned the overall hospital spending limits in the Tax Equity and Fiscal Responsibility Act of 1982,[25] and that radically reformed the payment system by instituting diagnosis-related payment for Medicare in the Social Security Amendments of 1983.[26]

The third premise is that state legislatures have become equal to the Congress in developing new legislative approaches to the health care cost problem. As the federal ability to control rising health care costs seems less apparent, states have moved independently to control inflation.[27] Of course, the states retain regulatory jurisdiction over the hospital industry and can co-regulate with the federal government. But more important than constitutional authority is the rationale on which state action rests. Fundamentally, state authority is based on the economic dependence of hospitals on revenues generated in the state and on the nature of the hospital as a firm. Once Medicare and the federal share of the Medicaid program are removed, sixty percent of hospital revenues come from local sources.[28] In addition, because of the typical non-profit, charitable nature of the hospital, the state's interest in regulation is heightened. Thus, the economic rationale for state intervention seems well-established.

The final premise is that state legislatures may be the preferred policy locus. Because the nature of the cost problem varies substantially from state to state, both in terms of its magnitude and its causes, and because the constellation of actors and the strength of the various interest

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[24]*See* Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, tit. XXIII, §§ 2161-2184, 95 Stat. 357 (codified as amended at 42 U.S.C. § 1396n (1982 & Supp. 1985)).

[25]Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 331-36 (codified as amended at 42 U.S.C. §§ 1395ww(a), (b) (1982 & Supp. 1985)).

[26]Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, § 601 *et seq.*, 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww(d) (1982 & Supp. 1985)).

[27]*See* Schramm, *supra* note 5, at 632-41.

[28]Gibson, Waldo & Levit, *National Health Expenditures, 1982*, 5 HEALTH CARE FIN. REV. 1, 19 (1983).

groups are different in each state, state legislatures are presumably more likely to craft acceptable solutions to meet local demands. Moreover, in our federal system, experience with a wide variety of state initiatives has the potential of increasing the development of more effective approaches to the problem of health care costs.[29]

Overarching each of the foregoing, however, is a fundamental concept of what role regulation plays in society. While many arguments have been advanced as to why regulation exists, it seems clear that in the case of economic regulation, the state is engaged in balancing interests that are not satisfactorily arbitrated in the market.[30] In response to actual or perceived market malfunction, the state enters to establish a distributional scheme (mainly by controlling entry and setting acceptable prices) that more adequately reflects an articulated social interest in the outcome of the economic exchange under scrutiny. In return for accepting a state presence, which necessarily reduces the discretion of the regulated enterprise, the state ensures some degree of security to the regulated entities. This quid pro quo reflects the fundamental nature of regulation: a formalized bargain where society exacts more acceptable behavior from the regulated firm in return for a promise of protection from some features of the unregulated marketplace.[31] Contemporary theory in state legislatures appears grounded on this exchange theory as opposed to the prevailing federal theory of unilateral delegation.

C. Primer on State Hospital Regulation

Modern state efforts at regulating the hospital industry began in the late 1960's.[32] In several states, controlling hospital cost inflation emerged as a matter for public concern and eventual legislation because of the public cost of care for the poor. In New York, where publicly supported care of the poor imposes a higher tax-related burden than in any other jurisdiction, inflation in hospital costs became a major issue in budget debates of the late sixties when it was apparent that New York City was close to financial collapse.[33] As part of the solution imposed by financiers, major reductions in spending, including for health care, were necessitated. Thus, the state established a program to supervise the

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[29]*See* Biles, Schramm & Atkinson, *supra* note 16.

[30]Breyer, *Analyzing Regulatory Failure: Mismatches, Less Restrictive Alternatives, and Reform*, 92 HARV. L. REV. 549, 553 n.17 (1979).

[31]*See* Stigler, *Theory of Economic Regulation,* in PERSPECTIVES ON THE ADMINISTRATIVE PROCESS 81 (R. Rabin ed. 1979); Wilson, *The Politics of Regulation*, in PERSPECTIVES ON THE ADMINISTRATIVE PROCESS 90 (R. Rabin ed. 1979).

[32]*See generally* Schramm, Wren & Biles, *supra* note 4, at 22.

[33]HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVICES, NATIONAL HOSPITAL RATE SETTING STUDY, VOL. VII: CASE STUDY OF PROSPECTIVE REIMBURSEMENT IN NEW YORK 2-8 (1980).

budgets of all hospitals, attempting to reduce spending for all payers, including Medicaid.[34]

The second state to establish a hospital cost containment program was Maryland, where hospital trustees were concerned that inner-city hospitals dealing with a higher-than-average caseload of indigent patients were in a state of fiscal stress and might be forced to close. As a result, trustees of the state's hospitals petitioned the legislature for an agency that would reduce hospital spending for all payers and distribute the expense of delivering care to the poor among all patients by establishing a uniform rate.[35]

In these two programs the seeds of the hospital regulation movement were planted. In both, the state stepped in to protect both the citizens who ultimately pay for care and the hospital system from financial insolvency related to uncompensated care. In each instance, the system of budget discipline imposed on the hospital was prospective payment for all care provided over a given period. Also, in both states all payers for care were made to pay the same price, thus allowing the costs of care provided to the poor to be redistributed over the entire patient population.

Shortly after the New York and Maryland legislatures established their programs, four other states initiated prospective hospital cost-containment programs.[36] Three of these states, Connecticut, Massachusetts, and New Jersey were in the northeast, where state legislatures had created substantial Medicaid programs in the mid-sixties. Because of the balanced budget requirements of state constitutions and recession-connected declines in tax revenues, these states were interested in reducing hospital cost inflation from a budgetary perspective. Another goal of the legislation was that both consumers and hospitals would benefit from a system that rationalized payment schemes among payers such that all citizens profited from reduced spending on hospital care.

Because of varying delays in collecting necessary financial information, all six states began regulating hospital rates at virtually the same time. Examination of the regulatory period from 1976 to the present

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[34]1965 N.Y. Laws 795 (codified as amended at N.Y. PUB. HEALTH LAWS § 2807 (McKinney 1985 & Supp. 1986)).

[35]*See* 1971 Md. Laws 627 (codified as amended at MD. HEALTH-GEN. CODE §§ 19-201 to 19-220 (Supp. 1985)).

[36]The states were Connecticut, 1973 Conn. Acts 117 (codified as amended at CONN. GEN. STAT. ANN. §§ 19a-145 to 19a-166 (West 1986)); Massachusetts, 1973 Mass. Acts 1229 (codified as amended at MASS. GEN. LAWS ANN. ch. 6A, §§ 31-77 (West 1986)); New Jersey, 1971 N.J. Laws 136; 1978 N.J. Laws 83 (codified as amended at N.J. STAT. ANN. § 26:2H-4.1 (West Supp. 1986)); and Washington, 1973 Wash. Laws ch. 5 (codified as amended at WASH. REV. CODE ANN. §§ 70.39.030 to 70.39.910 (West 1975 & Supp. 1986)).

has consistently shown statistically significant reductions in the rate of hospital cost inflation in the regulated states.[37] It is these data that in part account for the growing interest in hospital regulation at the state level.

D. State Activity to Date and its Classification

After nearly fifteen years, there are now several types of formal state-level initiatives to control hospital costs. The most extensive, typified by the first six states, is the regulation of total hospital revenues and the rates that all payers in the state are charged for care. In 1983, Maine, West Virginia, and Wisconsin enacted statutes similar to those in effect in the original six states.[38]

A second group of states are those that supervise hospital rates but do not have authority to set them. For example, in Florida, a public body exists to collect hospital price information and to disclose it publicly.[39] A third type of statute merely requires reporting of information on hospital prices to a state agency, which in turn may publish the information.[40] While it is still too early to judge the latter two types of efforts, ample evidence suggests that cost-containment programs are effective in direct proportion to the amount of government power vested in the regulating agency. Mere disclosure, for example, cannot be expected to be effective where consumers are fully insured against the costs of care.

II. The Parties and Their Interests

A. The Identities and Interests of the Twelve Groups

Most matters considered by legislatures evoke the attention of only two or three groups affected by a proposal. The groups include proponents (often private citizen/consumers, businesses, social reformers, and the executive departments of government) who seek legislative action on their behalf or on behalf of their cause; unqualified opponents of the proposal; and those who will be marginally disadvantaged by the measure and oppose its passage until the offending features have been discarded. When proposals that would limit hospital revenues are under consideration, however, at least twelve parties with distinguishable interests have been observed to take active roles. The presence of many interest groups makes the consensus necessary for the passage of leg-

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[37]Biles, Schramm & Atkinson, *supra* note 16.

[38]*See* Me. Rev. Stat. Ann. tit. 22, § 381 (West Supp. 1986); W. Va. Code §§ 16-5F-1 to 16-5F-6 (1985); Wis. Stat. Ann. §§ 54.01 *et seq.* (West Supp. 1986). See Appendix for a summary of a variety of state efforts.

[39]*See* Fla. Stat. Ann. §§ 395.501-395.514 (West 1986).

[40]*See* 1971 Cal. Stat. 1242.

islation problematic for two reasons: the process of multilateral negotiations is cumbersome and expensive, and the number of issues in dispute is extremely large.

As a result of the large number of interested parties, hospital rate-setting proposals present a curious legislative phenomenon; namely, unpredictable coalition behavior among the interest groups depending on the positions they adopt from state to state. Indeed, several of these groups have taken diametrically opposing positions in different jurisdictions. Compounding matters is the unpredictable identity of the "initiator" party from state to state.

What follows is a description of the interest groups and their respective positions on the question of regulating hospital revenue. The order in which they are presented does not reflect their importance to the legislative process. Once the groups and their causes are identified, the possible initiators of legislation are examined. Finally, the coalition behavior of the parties is explored and likely legislative outcomes—which ultimately depend on the nature and number of parties forming the most forceful coalition—are discussed.

1. Community Hospitals.—This group is composed of non-profit or voluntary, acute care community hospitals. More specifically, the interest group represents the position of professional administrators working in these hospitals. Their interests can often be distinguished from those who have a stake or interest in the hospital and its continued existence; for example, hospital trustees. As will be discussed in more detail below, community hospital trustees have traditionally represented what might be thought of as a long term local interest in the hospital.

The American Hospital Association (AHA), the national interest group whose membership is overwhelmingly composed of hospital chief executives, has vigorously resisted the adoption of rate setting. Reduced to its essence, the position of the AHA is based on the criticism that regulation reduces the managerial discretion of the professional administrator.[41] Professional administrators recognize that their interests might diverge from those of trustees, and the AHA has attempted to influence hospital trustees to its way of thinking. For example, the Association has established a separate trustee educational effort and has founded a magazine designed to influence trustees' perspectives.[42]

2. Hospital Trustees.—Trustees are more closely connected to the

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[41]*See Hearings Before the Subcomm. on Health of the Senate Comm. on Finance on State Hospital Payment Systems*, 97th Cong., 2d Sess. 236 (1982) (statement of the American Hospital Association); Knieser, *Free Market System Is Still the Best Answer*, 56 HOSPITALS 31 (1982); *see also* AM. HOSP. ASS'N, *supra* note 4; AM. HOSP. ASS'N, HOW STATES CAN OPT OUT OF THE FEDERAL MEDICARE DRG SYSTEM: A SUMMARY OF LEGAL ISSUES (1983).

[42]This magazine is TRUSTEE, published monthly by the American Hospital Publishing Co.

hospital's role in the community than many of the individuals who work in the hospital every day. To the extent that the hospital is viewed as a community-owned resource, often based literally on a financial trust dedicated to community welfare, trustees may view themselves as the custodians of a very special community asset.

In contrast to the essential "localness" of the trustee's interests, professional administrators participate in national labor markets, and their allegiance to a given institution often appears minimal. Whereas administrators, *qua* professionals, view themselves as important to the orderly functioning of the nation's hospitals, trustees represent community concerns and continuity of interest in the fortunes and successes of a local institution. Thus, from time to time, one can observe a clear divergence of interest between trustees and professional hospital leadership.

In the case of rate setting, a state presence may be desirable or at least less threatening to trustees who are members of the community elite and can informally make their voices heard in government circles. In Maryland, trustees initiated the movement that ultimately resulted in the creation of a state agency with authority to set hospital revenue limits; they saw government as the only means to distribute equitably the burden of uncompensated care and thus preserve the hospital system in a time of significant economic stress. Administrators, who as outsiders do not enjoy comparable government access, tend to view rate setting as an affront to their professional competence in making decisions related to hospital resource use.[43]

3. For-Profit Hospitals.—For-profit hospitals, whose political importance varies enormously from state to state depending on the share of hospital services provided by investor-owned hospitals, have always opposed rate-setting legislation. The basis of their opposition seems obvious; in regulated markets, firms have their profit level determined by a regulatory agency which customarily ties approved rates to actual costs of production plus a rate-of-return on investment. In such systems, investor-owned hospital executives believe that the freedom to seek maximum profit is removed. It appears that the resistance for-profit hospitals offer to state-level proposals to limit hospital revenue has little to do with the number of for-profit hospitals within a jurisdiction. Rather, the behavior of for-profit hospitals toward new rate-setting proposals suggests that the for-profit industry operates with the domino theory in mind—each additional state adopting hospital regulation, even if there is no significant investor-owned market share, increases the likelihood of regulation in other states.[44]

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[43]*See* Jolly, *Election Post-Mortem: Arizona Hospital, Business Health Cost Fight Fizzles*, BUS. & HEALTH, March 1985.

[44]*See* Statement by Cyndee Eyster, Director of State Legislation, Federation of American Hospitals, to the Special Committee on Health Care Cost Containment and the

4. Blue Cross.—Blue Cross plans were founded by hospitals as non-profit insurance schemes by which patients would fund hospital care through premiums.[45] As such, most state Blue Cross plans operate as specially chartered, non-profit, tax-exempt entities. Over the years, because of the close link between hospitals and Blue Cross (until the last decade overlapping boards of directors were common),[46] Blue Cross plans with larger market shares have enjoyed significant discounts from hospital charges in paying for their subscribers' care.[47] To the extent that rate-setting legislation would set hospital prices evenly among all payers, in an attempt to shift bad debt equitably among all hospitals and patients, Blue Cross will find the proposal objectionable because it will result in a major inhibition to maintaining what Blue Cross considers competitive rates.[48]

5. Commercial Insurers.—Because commercial insurance companies do not have direct contracts with providers as do Blue Cross plans (where the subscriber/patient stands legally as a third party beneficiary), but rather indemnify the insured/patient, they have not been able to extract discounts from hospitals. Commercial health carriers argue that as a result, virtually every other payer—because they contract directly with hospitals on behalf of a pool of patients, albeit an uncertain and unpredictable pool from the perspective of any one hospital—is able to extract some discount from hospital charges. Thus, commercial carriers argue that hospital administrators, in order to meet the demands for discounts made by direct payers (Blue Cross, Medicare, Medicaid, and workers' compensation), pass on the costs of this practice to those patients who pay full charges and seek indemnification from their insurers.[49] The practice of imposing higher charges on commercially insured patients, commonly referred to as cost-shifting, operates to disadvantage the indemnification carriers by raising their claims expenses. As a result, commercial insurers generally endorse cost-containment proposals which promise the equitable treatment of all payers.

6. Medicaid.—Every state except Arizona established a Medicaid program shortly after Congress passed the federal act in 1965.[50] Under the statute, Congress provided that roughly half of all costs of state programs would be met from the federal treasury provided that state programs included certain minimum benefits.[51] During the 1970's, Med-

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Human Resources Committee of the National Conference of State Legislatures (September 1984).

[45]S. Law, Blue Cross: What Went Wrong? 6-25 (2d ed. 1976).

[46]*See, e.g.*, Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 Iowa L. Rev. 1351, 1370-71 (1984).

[47]S. Law, *supra* note 45, at 1-5.

[48]Ginzburg, *Hospital Cost Shifting*, 310 N. Eng. J. Med. 893, 895-96 (1984).

[49]*Id.* at 897.

[50]Twenty Years of Medicare and Medicaid, *supra* note 11, at 16.

[51]Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I, §§ 121-122, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396 *et seq.* (1982 & Supp. 1985)).

icaid programs felt the financial strain of hyper-inflation in peculiar ways. State revenue is often more sensitive to general economic conditions because of sales tax, and the recessionary conditions of the seventies reduced state income substantially.[52] In states with relatively generous Medicaid programs, inflation in health care costs and a growing number of beneficiaries caused Medicaid expenditures to become a major part of state budgets by the 1970's.[53]

State budget officers have long seen Medicaid as particularly important to the fiscal condition of the state and have pressured Medicaid programs to reduce expenditures. Because federal law requires only minimum benefits and state enactments often expand the minimum, policy attempts to reduce costs have basically focused on three avenues. The first is to reduce the number of beneficiaries by readjusting eligibility standards for program coverage.[54] The second has been to pressure providers into giving Medicaid discounts against either charges or costs. These discount approaches have proceeded directly, for example by Medicaid unilaterally determining that it will not pay for inpatient care after, say, the twentieth day of hospitalization, or indirectly, by not increasing the payment for physician visits from amounts established as long as a decade ago.[55] The third approach has been to advance plans that would reduce the rate of inflation of costs in order to lessen the growth of the Medicaid expenditure from year to year.[56]

While governors may feel obliged to be sympathetic to the interests of hospitals and others who might be harmed by regulation, the condition of state budgets imposes a certain unavoidable demand on executives' allegiance. While cases exist where a state health department has publicly assumed a position on rate setting contrary to an executive's, such situations are rare and generally change once the governor imposes executive discipline.

7. Medicare.—For the most part, the federal government's role in the rate-setting debate at the state level has been minimal. In 1972, Congress sanctioned state hospital cost containment initiatives when it offered a waiver of Medicare reimbursement principles to those states experimenting with rate regulation.[57] Under this authority, several of the

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[52]THE REAGAN EXPERIMENT: AN EXAMINATION OF ECONOMIC AND SOCIAL POLICIES UNDER THE REAGAN ADMINISTRATION 157-219 (J. Palmer & I. Sawhill eds. 1982).

[53]Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1 (1983).

[54]R. BOVBJERG & J. HOLAHAN, MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES 25-32 (1982).

[55]INTERGOVERNMENTAL HEALTH POLICY PROJECT, RECENT AND PROPOSED CHANGES IN STATE MEDICAID PROGRAMS: A FIFTY STATE SURVEY (1983).

[56]R. BOVBJERG & J. HOLAHAN, *supra* note 54, at 38-45.

[57]Social Security Amendments of 1972, Pub. L. No. 92-603, tit. II, § 222, 86 Stat. 1390.

rate-setting states were granted Medicare waivers in which the federal government agreed to pay its Medicare obligations according to the rate schedule set by the state agency. In 1983, Congress mandated that if certain requirements were met by a state rate-setting agency, the Secretary of Health and Human Services, acting through the federal Health Care Financing Administration (HCFA), must grant a waiver to the applicant.[58] Notwithstanding the nondiscretionary nature of this congressional directive, the Reagan Administration, acting through the Office of Management and Budget, has taken a decidedly hostile approach to Medicare waivers.[59] The Administration seems to perceive rate setting as an objectionable advance of regulation in society and to believe that it should not be encouraged as a matter of policy.

Medicare's non-participation may influence state legislation regarding rate setting in the future. To the extent that rate setting is attractive because it imposes the same rate schedule on all payers, thus making all payers share equally in uncompensated care, federal participation is critical. Apart from its philosophical objection, the Reagan Administration does not support the waiver option because of its perception that Medicare expenditures have been higher in waiver states than they would have been under normal Medicare reimbursement methods.[60] Notwithstanding evidence to the contrary,[61] it remains to be seen whether the Administration will attempt to revoke federal participation in existing waivers or grant waivers to the new rate-setting states.

8. Business.—In recent years, business leaders have become increasingly active in the debate over solving hospital costs. Indeed, the interest of business has served to refocus the problem away from concern over hospital cost inflation to concern over both the absolute level of hospital prices and aggregate hospital spending in a given community.[62] Business has joined other interests, most notably organized labor, in an attempt to force a discussion of what might be done in the community to reduce total hospital budgets. In many cases, employers have acted to reduce actual claims expense.[63] Generally this action has involved pressuring hospitals and Blue Cross plans to reduce both utilization by employees and the unit prices charged by the hospital to employees.

This movement is significant because it represents the first time a

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[58]Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, tit. I, § 101(a)(1), 96 Stat. 334 (codified at 42 U.S.C. § 1395ww(c) (1982 & Supp. 1986)).

[59]*See, e.g.*, Washington Report on Medicine and Health, Oct. 29, 1984, at 38.

[60]*Id.*

[61]S. Renn, The Efficacy of Waivers (1984) (unpublished paper, The Johns Hopkins Center for Hospital Finance and Management).

[62]*See generally The Corporate Rx for Medical Costs: A Push for Revolutionary Changes in the Health Care Industry*, BUSINESS WEEK, Oct. 15, 1984, at 138-41.

[63]*See, e.g.*, Jolly, *supra* note 43; Meyerhoff & Crozier, *Health Care Coalitions: The Evaluation of a Movement*, 3 HEALTH AFF. 120 (1984).

major division between a community's employers and a community's hospitals has been observed. It probably reflects in part the decision by employers over the last decade personally to bear the risk of hospital costs by self-insuring.[64] Self-insurance has forced many Blue Cross plans to play the limited role of claims administration. As a result, if an employer is dissatisfied with its claims expense, it may move directly against a group of hospitals in an attempt to secure lower costs.

9. Organized Labor.—Fringe benefits, including health insurance, have long been regarded by the leadership of organized labor as one of unionism's greatest achievements.[65] Thus, there has been little historic concern over the matter of rising hospital costs since higher costs have been viewed as resulting in more and better care. Employers paid for all or most of the costs of insurance, and union leadership has been largely disinterested in the absolute cost of these benefits. However, in recent times, the growth of fringe benefit expenses has been so great that employers have been more aggressive in bargaining. Unions have experienced negotiations in which little or no increase in take-home wages was possible because fringe benefit increases had eaten away all that the employer was willing to give or all that labor was able to bargain. Faced with such a vital challenge to the bargaining process, union leadership has increasingly concluded that hospital prices must be controlled.

The position of organized labor regarding hospital rate setting has been ambivalent in the past and continues to be ill-defined despite an increased sense of its importance. In some jurisdictions where hospital workers are organized, revenue control of hospitals is perceived as inevitably leading to reduced employment. Recently, however, organized labor has officially determined that it supports the concept of hospital rate regulation and has worked on behalf of regulation in West Virginia.[66]

10. Consumers.—Consumers have only recently emerged as a force in rate-setting legislation. Because they have traditionally been shielded from the true costs of health care by comprehensive insurance, consumers have been relatively indifferent to inflation in this sector of the economy. Insurance carriers have historically paid the costs of health care no matter how fast unit prices increased. Consumer apathy has been exacerbated by the very nature of hospital care finance, a field so complex

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[64]*The Corporate Rx for Medical Costs: A Push for Revolutionary Changes in the Health Care Industry*, BUSINESS WEEK, Oct. 15, 1984, at 138-41; *see also* Iglehart, *Big Business and Health Care in the Heartland: An Interview with Robert Burnett*, 3 HEALTH AFF. 40 (1984).

[65]*See* Dunlop, *Health Care Coalitions*, in PRIVATE SECTOR COALITIONS: A FOURTH PARTY IN HEALTH CARE 10-11 (B. Jaeger ed. 1982).

[66]WEST VIRGINIA LABOR FED'N (AFL-CIO), COMMITTEE ON POLITICAL EDUCATION, LEGISLATIVE REPORT SIXTY-FIFTH LEGISLATURE 16 (1982).

that it would require a substantial investment of time for individuals to comprehend the extent of their coverage and their exposure.

However, recent erosion of the fully protective nature of insurance, evidenced by increased copayments and deductibles, coupled with the erosion and threatened cutbacks in programs protecting the elderly and the poor, have forced more consumer advocates to turn their attention to the issue of rising health care costs.[67] Nearly all consumers have faced reductions in current coverage. Employer and union approaches have primarily involved reductions in the "first dollar" aspects of coverage in an attempt to make the consumer more price conscious and thus more judicious in the use of care.[68] Similarly, Medicare and Medicaid have been attempting to control provider (hospitals and physicians) expenditures for several years with little success. As a result, both programs have turned their attention to the patient/beneficiary as a means of curbing program costs in light of uncontrollable provider behavior.

11. Physicians.—Physicians always resist proposals to control hospital revenue. Their objections appear founded on the notion that if hospital revenue is constrained, ultimately the freedom of the physician to make choices related to the use of the hospital will be reduced. To the extent that physicians make a disproportionate share of their income from activities related to patient care in hospitals,[69] rate regulation is seen as a potential negative force on physician incomes. Others have suggested that physician resistance is based on the domino theory—if hospital prices are regulated, physician prices will be next. Recent action by the Congress in the 1984 Medicare amendments suggests this fear may not be groundless.[70]

12. Nurses.—Nurses have not played an important role in the rate-setting debate as yet. Where they have been visible, in only a handful of states, their resistance has been orchestrated by the state hospital association. Indeed, the only position taken by spokespersons for nursing interests has been that regulation has adverse effects on patient care.[71] Putting aside the quality issue, however, regulation will have no evident

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[67]*See* AM. ASS'N OF RETIRED PERSONS, 1985 FEDERAL & STATE LEGISLATIVE POLICY (1985).

[68]*See* Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117 (1981); *see also* Goldsmith, *Death of a Paradigm: The Challenge of Competition*, 3 HEALTH AFF. 5 (1984).

[69]*See* Showstack, Blumberg, Schwartz & Schroeder, *Fee-for-Service Physician Payment: Analysis of Current Methods and Their Development*, 16 INQUIRY 230 (1979).

[70]*See* Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2306, div. B, tit. III, 98 Stat. 494, 1070 (amending 42 U.S.C. § 1395u(b) (1982)).

[71]*See* Schramm, *Economic Perspectives on the Nursing Shortage*, in NURSING IN THE 1980's, at 55 (L. Aiken & S. Gortner eds. 1982).

economic impact on nurses other than potentially reducing system-wide demand for nurses involved in inpatient care.[72]

Any description of the actors and their interests would be incomplete without noting that members of legislatures have their own interests to advance on the issue of hospital regulation. Most legislators have hospitals in their districts, which have tutored them on the causes of hospital inflation and the evils of rate setting. On the other hand, legislators inevitably deal with larger social issues and are compelled to behave with state-wide interests relative to the state's budget. This tension between serving the interests of their constituent hospitals and the needs of the state sometimes makes the issue of hospital cost control troublesome for legislators. The very nature of the hospital cost control problem, i.e., its complexity, persistence, and political intractability, makes it more amenable to a regulatory solution whereby the legislature delegates its authority to a continuing agency. This approach takes hospital decisions out of the hands of the legislature and places them in the "independent" branch of government where politicians cannot be held responsible for the outcome of the regulatory process.[73]

B. The Initiator

One of the most interesting aspects of the legislative process relating to hospital cost containment is the changing identity of the initiator of regulatory efforts from state to state. As one might suspect, the parties involved have somewhat different interests in each state. For example, in jurisdictions where Blue Cross market penetration is significant, sizable discounts against charges are often encountered. In these states, Blue Cross would clearly oppose any action to equalize rates among payers. On the other hand, in states where Blue Cross does not enjoy such discounts, Blue Cross might look upon rate regulation as a positive development designed to keep claims expense under control.

Based on experience to date, the parties that have first presented the idea of regulating hospital rates have included hospital trustees, governors, business, commercial insurers, and consumers. In each case, the interest in the issue is different. Trustees see rate regulation as a means of protecting hospitals from unequal exposure to bad debt expense, thus stabilizing the industry as a whole. Governors espouse the notion of controlling hospital inflation as a means of dampening the demand of state Medicaid programs for general funds. Business leaders have advocated regulation out of frustration with hospital inflation. Commercial insurers see regulation as a means of equity in payment and

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[72]*Id.* at 44-49.

[73]Kinney, *Coordinating Rate Setting and Planning in States with Mandatory Hospital Rate Regulation: What Makes a Difference?* (to be published in Journal of Legal Medicine).

protection against cost shifting. Finally, consumers have argued for rate controls to address the growing burden of insurance copayments and deductibles.

Obversely, certain parties have never supported rate regulation, much less acted as proponents. These include hospital associations and the investor-owned hospitals, medical societies, and nurses. The perception of each group is that if rate review legislation were to emerge, its economic interest might be impaired.

Several actors have been on each side of the issue in different states, and on each side of the issue in the same jurisdiction, but in different periods of time. Business has been divided on whether regulations are necessary. As mentioned above, many business leaders abhor the notion of encouraging the spread of regulation, notwithstanding their perception that hospitals will not establish spending restraints on their own. Likewise, organized labor has historically resisted hospital regulation as an implicit reduction in the benefits available to members and as a potential threat to the jobs of the many unionized hospital workers. A final example of ambiguous support is the action of Governor James Thompson of Illinois, who endorsed legislation designed to establish a hospital regulation agency and then failed to appropriate the funds needed to give it life.[74]

In conclusion, one is reminded of the work of Anthony Downs regarding the factors that make issues the subject of public, specifically legislative, attention. Downs argues that ideas move into public debate and are dealt with depending on the parties introducing the idea and the amount of public support the idea receives.[75] The crux of Downs' theory is that issues change through time, and predicting what action will emerge depends largely on who initially brings an idea to public attention. In the case of rate setting, because of the large number of interested parties, the importance of the initiator of the idea is overwhelmed by the identity of parties who support the notion.

C. Coalitions of Parties and Their Behavior

While the formation of coalitions is key in understanding the process that brings hospital revenue regulation about, there is little systematic knowledge about the operation of joint interests. There are, however, certain groups whose interests seem to coincide and others where certain antipathy is observed. The most commonly observed link is between commercial insurers and employers, if employers are at all active on the issue. Likewise, the bond between hospitals and Blue Cross seems certain.

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[74]*See* Crozier, *State Rate-Setting: A Status Report*, 1 HEALTH AFF. 74 (1982).

[75]Downs, *Up and Down with Ecology: The "Issue-Attention Cycle,"* 28 PUB. INTEREST 38 (1972).

In most cases, the similarity of positions between trustees and hospitals prompts joint activity to resist rate setting. Increasingly, where business has taken a positive stand, it is supported by organized labor, due largely to the formal existence of labor-management coalitions.

Just as certain parties find it in their interest to work together, the opposite also holds. Blue Cross and commercial insurers seldom appear to work together, just as physicians never join employers or unions in their positions. Similarly, for-profit hospitals will never work with organized labor. Medicaid, Medicare, and organized nurses generally operate on their own and seldom become an integral part of any coalition.

D. Likely Outcomes—Predicting Success or Failure

In the legislative process, it is always difficult to predict success or failure with any certainty. Considering the enormous diversity among state legislatures, it is virtually impossible to develop a paradigm that would be useful in forecasting the outcome of a drive to bring about hospital rate regulation. However, several postulates appear helpful in understanding the legislative disposition of hospital revenue control proposals. The first is that no one group can be successful in a legislative campaign. It appears that some majority of the more important actors must support legislation in order for it to pass. The second postulate is that active opposition by a small number of key interests can prevent passage. It appears that hospitals, working with Blue Cross, have generally been successful in preventing passage, especially if trustees have been active in their resistance. The third postulate is related; namely, no one group can prevent passage. Acting alone, hospitals, physicians, organized labor, and Blue Cross have been unable to prevent the passage of rate-setting legislation.

The net importance of these observations is that one must watch the joint behavior of the parties surrounding a legislative proposal. Success or failure lies in the coalitions that effectively work for or against the proposal.

III. Positions of the Parties

A. The Context of Argument in the Legislative Milieu

Having observed the legislative and executive process related to hospital rate regulation in several jurisdictions, it is possible to inventory the major positions advanced by proponents and opponents of regulation. Because of the apparent interest in the phenomenon, this Article gives limited attention to the arguments in favor of hospital rate regulation. Instead, it concentrates in more detail on the arguments offered by opponents. This approach should prove more useful in understanding

the legislative process, as legislation typically succeeds more by overcoming negatives than by being embraced for its obvious utility to society.

B. Why Hospital Rate Setting?

The statistical case that rate-setting achieves the objectives of legislation establishing a regulatory mechanism for hospital revenues is rather easily made and, indeed, is nearly universally confirmed by evaluative research on the effects of the regulatory process.[76] In the post-1976 regulatory era, the rate of increase in the cost of an average hospital admission has risen more slowly in the original six rate-setting states than in the 45 remaining jurisdictions—a finding of particular interest given the contrary inflationary experience of the six states in the pre-regulatory period.[77] Inflation in the cost of a hospital stay is a convenient proxy for measuring the effectiveness of the legislation in accomplishing its goal of reducing overall inflation.

C. Arguments on Behalf of Rate Setting

Given the success of the original state efforts to control hospital spending, it is interesting to examine the arguments advanced on behalf of hospital revenue regulation more carefully. It is important, however, to appreciate that for the most part, the success of rate setting has been linked to its ability to impose the same rate on all payers for hospital care. In most states, hospitals charge a variety of prices for the same services depending on the source of payment. Thus, cash paying patients and those insured by indemnity policies (commercial insurance) are referred to as charge-based payers because they pay for the actual cost of their care plus a markup to the charged price. Medicare and many state Medicaid plans have traditionally paid "reasonable costs," with no markup over the actual cost of providing care for the beneficiaries. In four of the original rate-setting states, the federal government, using its authority to waive Medicare regulations, agreed to reimburse hospitals at the rates set by the state agencies. In several states, Medicaid programs pay less than actual costs by setting lower-than-cost fee schedules for hospital care. In between are payers such as workers' compensation carriers that pay according to a fee schedule, Blue Cross plans which generally pay charges minus a contractually-agreed discount, and other

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[76]*See, e.g.*, Biles, Schramm & Atkinson, *supra* note 16; Sloan, *Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade*, 61 MILBANK MEM. FUND Q. 195 (1983). *But see* Mitchell, *Issues, Evidence, and the Policymaker's Dilemma*, 1 HEALTH AFF. 84 (1982); Morrisey, Sloan & Mitchell, *State Rate-Setting: An Analysis of Some Unresolved Issues*, 2 HEALTH AFF. 36 (1983).

[77]See Appendix, Fig. 1 for the rate of cost increases in the original six states and Figs. 2-7 for the experience in each of the six.

payers who have entered into agreements for discounts with the hospital. Clearly, the existence of multiple price schedules in hospitals suggests the existence of cross-subsidization of costs among patients depending on payment source.[78] In this respect, the average hospital operates as an implicit social taxing scheme on its patients.

The most important argument advanced for the initiation of rate-setting is that it clearly establishes strong incentives to reduce price inflation and ultimately to reduce the underlying costs of hospital care. To the extent that certain price levels are disallowed by the agency, the hospital must act to reduce costs.

The second most persuasive argument relates to the uniform price imposed in "all-payer" states; namely, that hospitals find all patients equally attractive. In states where different rates of reimbursement attach to different patients, equal access to hospital care is jeopardized. Hospitals clearly find certain patients more attractive than others. Likewise, where the state agency adjusts the uniform price in each hospital to reflect the cost of caring for poor patients, the hospital can be immunized against the risk of uncompensated care to those patients who have no form of insurance protection. Thus, discounts are awarded only to payers who offer demonstrated cost savings to hospitals, and no payer bears an unequal obligation to subsidize the care of uncovered patients. Related to inter-payer equity is the removal of any cause for hospitals to tax certain payers by "cost-shifting" unmet expenses from some patients to others.

Finally, in a package of attributes that might be characterized as management reforms, hospitals in regulated jurisdictions operate within a more predictable revenue environment, with a consistent set of incentives and payment methods from carrier to carrier. Further, due to the public collection of information, hospitals in regulated jurisdictions find evaluation of comparative performance easier.

D. Arguments Against Hospital Revenue Regulation

Opponents of hospital revenue regulation fall into two types: those who oppose regulation in general and those who object specifically to hospital rate control. The former adapt general economic arguments against regulation to the hospital setting. The latter argue from experience and use the record of hospital regulation in other jurisdictions as evidence of why regulation should not be adopted in the instant case. In the legislative milieu, these theoretical and experiential arguments are both used simultaneously and are often confused with each other.

1. Adverse Effects of Hospital Regulation in General.—The general

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[78] *See generally* B. Kinkead, Pricing Policy in the Hospital Industry (1984) (unpublished thesis, Johns Hopkins University).

arguments against hospital regulation are variants of well-known anti-regulatory reasoning that has developed over the hundred-year span of regulation in America. The most important generic argument relates to the effect of regulation on competition and the operation of market forces. Quite clearly the most commonly shared value in the American economy is the importance of freely functioning markets. Our commercial creed is based on the notion that markets act to distribute goods impartially in a manner that maximizes efficient production and equitable distribution. Notwithstanding the importance of this economic tenet, our history since the advent of industrialism has been rife with tension between parties attempting to control markets and maximize profits. In the early phases of industrialism, private interests appeared to consolidate capital, manufacturing, and distribution networks in order to reap "monopoly" profits. As government responded to perceived abuses in the market by enacting antitrust laws, it appeared as if government was seeking to regulate markets in the interest of the consumer. Most economists believe, however, that government regulation of markets merely reflects a transformation of the mechanism by which large commercial interests operate to protect their market shares and, consequently, their profits.[79] Thus, economists argue that while business interests vociferously oppose regulation in general as destructive of the working of the free market, many businesses enjoy and seek government intervention in ordering the market in which they operate.

The foregoing demonstrates that regulation has been ubiquitous in our economic order for nearly one hundred years. That regulation is antithetical to the operation of free markets is not clear from history, nor is it clear that consumers would tolerate an exclusively competitive market.[80] Indeed, as suggested above, the existence of regulation in an industry cannot be interpreted as the triumph of government over private interests. Rather, it suggests that a public presence has been introduced as an implicit bargain which occurs through our political process. Consumer/voters acting through their government have extracted price concessions in exchange for a government promise to protect the regulated industry from potential competitors and sagging profits. From this perspective, it is difficult to view the position that regulation is antithetical to competition and our free market tradition as anything but a historic and simple perspective on a tremendously complex issue.[81]

Closely linked to the argument that regulation is anticompetitive is the position that it inhibits innovation and experimentation. Much of what we value in the free enterprise system are the dynamics of the constant vying for market share. As a result, competitive firms are forced

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[79] *See* Stigler, *supra* note 31.

[80] *See generally* S. Breyer, *supra* note 13, at 1-35.

[81] *See generally* H. Commager, The American Mind (1950).

to innovate and experiment with new products. In a regulated market, it is feared that formal entry rules will inhibit new competitors, and that existing firms will no longer feel pressured to innovate and seek improved efficiencies. As a result, consumers will not benefit from lower prices over time.

A third general argument against regulation is that the transaction costs of regulation are excessive. For example, regulated firms must bear the additional legal and administrative costs of complying with rules that are not imposed by the marketplace as well as the process-related costs of seeking government approval for decisions. The burden of these process costs is passed on to consumers. Surveys by hospital associations suggest that the costs of complying with regulatory requirements add substantially to hospital costs.[82] Moreover, some argue that the costs of regulation are borne disproportionately by regulated firms and that larger firms bear relatively heavier costs than smaller firms. In any event, the distillate of these claims is that regulation is costly and that the burden of these costs does not fall neutrally on all firms.[83]

The final contention against regulation is that it intrudes into the decision-making authority of management. In the case of hospitals, it is further argued that regulation eventually invades the clinical decision making of physicians.[84] Regardless of the motive for regulation, the very nature of the process circumscribes the authority of managers and administrators. The existence of a public agency charged with setting operating rules for the industry and monitoring the behavior of regulated firms is the mechanism whereby the public's interest in the firm's decision making is presumably established.

The arguments against regulation in general meet peculiar difficulty when applied to hospitals. Regarding the theory of imposing a public interest in the decision making of the hospital, it must be remembered that the typical hospital was established as a public service entity, in nearly all instances as a non-profit, charitable institution.[85] It is therefore curious that hospitals would resist the imposition of a regulatory scheme whose rationale is to protect the public from the unbridled discretion of the regulated entities. Likewise, regarding regulatory costs in the hospital industry, many of the regulatory strictures already in place were developed by hospitals themselves in an attempt to develop uniform

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[82]*See, e.g.*, HOSP. ASS'N OF NEW YORK STATE, COST OF REGULATION, REPORT OF THE TASK FORCE ON REGULATION (1978); Lewin, Sommers & Sommers, *State Health Cost Regulation and Administration*, 6 TOLEDO L. REV. 647 (1975).

[83]*See* Cutler & Johnson, *Regulation and the Political Process*, 84 YALE L.J. 1395 (1975).

[84]*See* Zuckerman, Becker & Adams, *Physician Practice Patterns Under Hospital Rate-Setting Programs*, 252 J. A.M.A. 2589 (1984).

[85]*See* AM. HOSP. ASS'N, HOSPITAL STATISTICS, 1986 ed. 18-19, Table 5A (1987).

standards for their industry. Indeed, few if any industries in our economy have been so persistent in establishing self-policing bodies such as the Joint Commission on Accreditation of Hospitals (JCAH) or in seeking legislative delegation to these private regulatory efforts.[86] For example, a hospital can become a certified Medicare provider and qualify for federal payment simply by receiving JCAH accreditation.[87]

2. Specific Adverse Effects of Hospital Regulation.—The specific adverse effects of hospital regulation are generally associated with a particular interest which might be offended. For this reason, the problems with regulation will be examined from five perspectives.

a. Financial effects on hospitals.—Because revenue is affected, hospitals argue that regulation seriously erodes their short and long term financial strength. In the short term, it is argued that regulation affects the liquidity of the hospital, threatening its ability to meet current liabilities from current revenues. Through time, the additive nature of this revenue shortfall is said to threaten the hospital's solvency. As a result, accumulated capital resources, particularly endowment funds, are used to the long-term detriment of the hospital's fiscal stability.

On the basis of Stigler's theory of regulation, one would not expect this outcome.[88] Indeed, one would suspect that the presence of regulation would lead to a strengthened fiscal position for the hospital. Some evidence suggests that this is so. While hospital operating margins in the first six regulated states were lower than in other jurisdictions, through time hospitals in regulated states have experienced constant improvement in their margins relative to their past and to the non-regulated jurisdictions.[89]

Related to the argument that their fiscal status is jeopardized by revenue regulation is the hospitals' contention that the presence of a regulatory scheme operates as a liability in hospital capital markets. This contention is important because public capital markets have become increasingly important to hospitals in recent years.[90] Roughly a decade ago, most new capital investment in hospitals was funded through philanthropic gifts and accrued surpluses; now, however, most new construction is funded through revenue supported debt obligations sold by hospitals on the public bond market.[91] Should a hospital operating in

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[86]II A HOSPITAL LAW MANUAL, *Licensure* 1 (1980).

[87]*See* 42 U.S.C. § 1395bb (1982 & Supp. 1985). *See generally* Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care in the Public Interest*, 24 B.C.L. REV. 835 (1983).

[88]*See* Stigler, *supra* note 31.

[89]*See* Appendix, Fig. 8.

[90]*See generally* D. COHODES & B. KINKEAD, HOSPITAL CAPITAL FORMATION IN THE 1980's (1984).

[91]*Id.* at 51-53.

a regulated environment find its ability to place revenue bonds impaired, it could greatly increase the cost of debt service through the life of the obligation. While investors may have previously viewed the hospital rate-setting agency as an impediment to the hospital's ability to set rates at levels sufficient to support its debt service, hospital capital markets are now taking comfort in the presence of an agency which, among other goals, seeks to insure the hospital from bad debt (traditionally the greatest threat to an institution's long-term solvency), and which has had a demonstrable positive effect on operating margins.[92]

b. Adverse effects on medical practice and the organization of the market for care.—Perhaps the most important argument relating to the advent of regulation is that is has unintended and counterproductive consequences. Most of these "secondary" effects relate to changes in medical practice and a reorganization of the medical care delivery system in response to the establishment of a regulatory system.

These observations generally rest on the early utilization experience of hospitals during the first years of hospital rate regulation. Initially, rate-setting methods focused on controlling the rate of change in unit prices within the hospital for all services delivered to patients.[93] In response, quite naturally, hospitals began to increase the volume of units delivered in order to protect overall revenues. Likewise, there is some evidence that hospitals encouraged increased admissions, again to protect the level of revenues.[94] Soon after this response was observed, regulatory agencies developed new rate-setting methods which established positive incentives for hospitals to reduce overall costs. Thus, regardless of the change in the regulated price per unit of service, the hospital would attempt to reduce the overall budget. One such approach developed in Maryland is referred to as the Guaranteed Inpatient Revenue System.[95] Here, as in the recently adopted federal Medicare payment system, a hospital is paid a set amount per admitting diagnosis. Under the Maryland system, at the beginning of the fiscal year, the agency promises a prospectively agreed upon budget to a hospital producing care for a given number of cases of a certain complexity (based on its historic experience) as measured by diagnostic groups. Should a hospital deliver

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[92]*See, e.g.*, EFFECTS OF NEW JERSEY'S DRG HOSPITAL REIMBURSEMENT SYSTEM ON HOSPITALS' ACCESS TO CAPITAL MARKETS, REPORT OF THE HEALTH RESEARCH AND EDUCATIONAL TRUST OF NEW JERSEY (1983).

[93]HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVICES, FIRST ANNUAL REPORT OF THE NATIONAL HOSPITAL RATE-SETTING STUDY: A COMPARATIVE REVIEW OF NINE PROSPECTIVE RATE-SETTING PROGRAMS (1980).

[94]Worthington & Piro, *The Effects of Hospital Rate-Setting on Volumes of Hospital Services: A Preliminary Analysis*, 4 HEALTH CARE FIN. REV. 47 (1982).

[95]For a description of the Guaranteed Inpatient Revenue System, see Esposito, Hupfer, Mason & Rogler, *Abstracts of State Legislated Hospital Cost-Containment Programs*, 4 HEALTH CARE FIN. REV. 129, 143-44 (1982).

care under budget, it keeps fifty percent of all savings. Thus, the hospital has a strong incentive to improve internal efficiency and not to increase volumes.

A second undesired effect of regulation is the reordering of the market resulting from efforts to avoid the reach of the rate-setting agency. Increasingly, hospitals have been attempting to diversify into a large number of out-of-hospital ventures, including off-campus ambulatory surgical facilities, nursing homes, and diagnostic centers that are not traditionally within the contemplation of the enabling statutes. As a result, hospital rates may be held constant but overall spending on health care may accelerate as hospitals "unbundle" their services, intending to maximize revenue by developing whole new markets. This phenomenon points out one area for improvement needed in regulation, namely, control of capital decisions related to the situs of health care. Most communities are burdened with excess hospital capacity. Increasingly, it appears, more efficient and cheaper treatment sites such as ambulatory care facilities and HMO's are being developed. As this trend continues, the overinvestment in unnecessary hospital capacity becomes more acute. Therefore, states should consider removing inefficient capacity by closing or encouraging the merger and consolidation of existing facilities.[96]

c. Adverse effects on payers.—Obviously, if regulation operates well, payers should benefit by having their claims expense reduced. However, all payers will not be equally affected, just as all payers will not have an equal interest in hospital cost containment. Hospital revenue regulation may have beneficial results for some and harmful effects for others. Before examining the impact of regulation on various payers, it is important to remember that in non-regulated jurisdictions, real hospital costs differ substantially from one payer to the next.[97] To the extent that rate setting sets a uniform price for all payers, those presently enjoying price concessions (in many states, everyone except cash-paying patients and indemnity or commercial insurance carriers) will resist regulation. It is also important to note that from the perspective of some carriers, the fundamental premise of controlling hospital price inflation may not be in their interest. For those carriers who have their rates established by state insurance commissions (all carriers except Medicare and Medicaid), premiums are often set on the basis of claims expenses plus some allowance—usually a percentage of expenses for administrative costs. Thus, these carriers have actually benefited from rising a hospital costs!

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[96]*See, e.g.*, FINAL REPORT OF THE GOVERNOR'S COMMISSION ON OHIO HEALTH CARE COSTS (July 9, 1984); FINAL REPORT OF THE GOVERNOR'S TASK FORCE ON HEALTH CARE COST CONTAINMENT (State of Maryland, Dec. 14, 1984).

[97]*See generally* Ginzburg, *supra* note 48.

In regulatory systems where hospital costs will be controlled for a subset of payers (e.g., Medicaid and Blue Cross—a system once in effect in Massachusetts), costs will unavoidably be shifted to the unregulated payers. If the regulated cost of a stay is set lower than the average prevailing in the hospital, and the institution cannot shift its cost curve in the short run, it will attempt to shift the shortfalls incurred in serving patients covered by regulated payers to patients to whom the hospital is free to charge any price. As hospitals shift unmet expenditures, the unregulated carriers may experience a relatively higher rate of claims cost than prevailed in the pre-regulatory period. This cost-shifting burden has been felt most heavily by commercial carriers who, because of their indemnity relationship with their insureds, are among the last payers whose rates are included in regulation.[98]

Closely related to the issue of cost-shifting among payers treated unequally by rate setting is the burden an all-payer approach might place on the state treasury should Medicaid be required to pay at the same rate as other payers. Especially in jurisdictions where the state Medicaid program has unilaterally established payment schedules substantially below the rates charged to other payers, the legislature will find it difficult to deal with the initial costs of reestablishing Medicaid payment at equal levels. In 1982, for example, Governor Thompson of Illinois decided that even though he had endorsed a hospital regulatory program enacted by the legislature, the cost of bringing the state's Medicaid payments up to those required by the all-payer nature of the program was too high, and the legislation was never implemented.[99]

In addition to the adverse effects that concern both the commercial insurers and Medicaid programs, there is concern that Medicare obligations increase in states where the federal program reimburses at rates established by state agencies. The federal government may choose in certain jurisdictions to pay at rates other than its nationwide payment method.[100] As noted previously, in an attempt to stimulate state experimentation with all-payer rate setting, Congress recently enacted statutory language providing that any state enacting comprehensive regulatory programs that set hospital rates for all payers would qualify for a waiver of the Medicare payment method. The Reagan Administration has viewed the proliferation of hospital rate setting as an undesirable expansion of government regulation.[101] It has argued that where Medicare pays rates in accordance with all-payer systems, the total cost to the Medicare program exceeds what would have been paid under prevailing payment principles. However, recent studies have established that Medicare pay-

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[98] *Id.*

[99] *See* Crozier, *supra* note 74, at 74.

[100] *See* S. Renn, *supra* note 61, at 1.

[101] *See* Washington Report on Medicine and Health, Oct. 29, 1984, at 38.

ments in the regulated states where the federal government has waived its payment principles have in fact been substantially lower than they would have been absent the waiver.[102]

The final payer adversely affected by rate-setting legislation is Blue Cross. As noted above, many Blue Cross plans enjoy discounts against charges because of their close connection with hospitals, their policy of not contesting claims, and their assurance to hospitals regarding method of payment. To the extent that an all-payer system would reduce these discounts or limit them to their economic value to the hospital, Blue Cross will be adversely affected since it will have to compensate for the resulting increase in claims expense by increasing premiums in the short run.

d. Adverse effects on patient/consumers.—Two arguments are advanced relating to the adverse effects of regulation on patients. The first suggests that one of the inevitable outcomes of regulation is the rationing of care. This argument holds that when hospital budgets are constrained, less care will be delivered and some hospital needs of the population will go unmet. The argument assumes that productivity within the hospital cannot be improved and that the level of hospital care currently delivered is medically necessary. Indeed, the weight of all the evidence related to this question indicates that we are oversupplied with hospitals.

The second adverse consequence of regulation from the patient's perspective is its potential impact on the quality of care. In reasoning similar to that underlying the rationing argument, opponents of hospital revenue limits suggest that with fewer resources at the physician's command, the patient will be deprived of necessary services and supplies for maximum quality care. Because there are virtually no scientific measures of quality available, any statement about quality can be nothing more than expert opinion. It could, in fact, be argued that by setting resource constraints on hospitals, one of the benefits to emerge will be strong incentives to examine treatment outcomes more carefully so as to optimize resource use.

e. Adverse effects on hospital employees.—The final category of arguments against rate setting is that it will have adverse effects on those who are economically linked to the continued well-being of individual hospitals. While the number of individuals potentially affected by a reduction in spending on hospital care is extremely large, hospital employees are likely to be the most immediately affected by any potential reduction of hospital revenue. One reason why this group receives such attention is that if a hospital is to keep its operating expenses in line with permitted revenues, it must focus attention on labor costs. Labor costs alone account for over sixty percent of hospital expenses.[103]

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[102]*See* S. Renn, *supra* note 61.

[103]Am. Hosp. Ass'n, Hospital Statistics 23 (1984).

Concern over the impact of hospital regulation on employment is most commonly articulated in two arguments. First, hospitals will move to reduce labor expenses before any other cost-cutting approaches are taken. Obviously, because labor expenses account for such a high share of total costs, attention will be focused on reducing labor costs by layoffs and/or reductions in pay levels. In the case of layoffs, enormous political pressure builds on local officials to seek ways of expanding the hospital's budget in order to protect jobs. In the case of wage reductions, employees generally find such steps enormously unnerving to their sense of security, and the hospital adopting such a strategy may jeopardize organization morale.

The second labor-related argument is akin to the first but reflects a more subtle approach to reducing labor costs. It involves the substitution of higher-skilled with lower-skilled and lower-paid workers. For example, faced with new budget constraints, a hospital might attempt to substitute registered nurses with lower-paid practical nurses, or it might attempt to use nurse anesthetists in conjunction with physician anesthesiologists. There is some evidence, however, that in regulated situations some hospitals attempt to improve efficiency by replacing lower-skilled persons with fewer, more highly paid personnel.[104]

IV. Discussion

The issue of regulating hospital rates will grow in importance in the future. Indeed, state legislative activity in this area will increase, as will other avenues to establish a formal role for state government in the regulation of hospital finances. One of the most interesting lessons from observing legislative proceedings in eighteen states is the unpredictability of the outcome. As mentioned at the outset, the multiplicity of parties and the inconsistency of their coalition behavior from state to state make the legislative process very difficult to control, and often it appears a risky investment for those seeking to enact rate-setting laws.

Examining the legislative outcome in several states suggests the difficulty of working through legislation relating to hospitals. Of the eighteen states where legislation has been proposed or introduced during the last three years, laws have emerged in only three. While it is difficult to draw comparisons with other types of legislation, this success rate seems particularly low. On the other hand, previous observations suggest that there is a long gestation period for statutory proposals to limit hospital revenues. Moreover, the hospital industry nearly always ranks among the largest in terms of aggregate budgets in any state.

In response to the unpredictability and difficulty of pursuing a legislative program, recently it appears as if those seeking cost contain-

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[104]Schramm, *supra* note 71, at 45.

ment through the regulation of hospitals have taken new non-legislative approaches. By far the most dramatic has been the referendum attempt conducted in Arizona in the fall of 1984. Here, a coalition of major businesses interested in the establishment of a regulatory system for hospital budgets was urging a rate-setting bill upon the state legislature.[105] The hospitals' opposition was extremely strong and the legislature was apparently deadlocked. As an avenue for circumventing the legislature, the employer coalition ran a successful drive for a state-wide referendum in November of 1984. The legislature similarly developed several proposals related to hospital costs and placed them on the November ballot. Likewise, the hospitals developed a referendum proposal calling for limited regulation. In all, five regulatory proposals went before the voters. None passed despite what appeared in exit polling as a strong commitment to the idea by a majority of the voters. Explanations of the results vary, but the important observation here is that while the legislative route may prove difficult, the shortcut of referenda seems equally if not more unpredictable. Similar referendum campaigns have been discussed in other states, but since the Arizona experience, interest in the idea appears to have declined.

An emerging alternative to hospital revenue legislation seems to be attempts to change the underlying causes of the problem of high absolute hospital cost. In general, these approaches appear to focus on two separate issues—one institutional and the other more market-oriented. The first relates to the oversupply of hospital beds. For over twenty years, the connection between excess hospital beds and high costs has been recognized and has motivated policy at both the federal and state levels. In the last few years, however, with admission rates, length of stay, and overall occupancy falling in the nation's hospitals, the issue of excess capacity has taken on added importance from the perspective of reducing hospital costs. This results from the now widely observed phenomenon of hospitals attempting to compete with each other to fill beds—often at the risk of unnecessary hospitalizations—and from the costs of carrying overhead expenses on unfilled beds. Several states have recently published studies showing that as much as one third of their bed supply is unneeded.[106] As a result, the states are taking action to remove hospital beds through a series of legislative proposals that involve redeveloping hospital capital into other uses, public "buy-outs" of existing hospital debt, and exemptions to antitrust laws in order to encourage mergers and consolidations between hospitals.[107]

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[105] *See* Jolly, *supra* note 43.

[106] *See generally* Ohio and Maryland Commission reports, *supra* note 95.

[107] *See* INTERGOVERNMENTAL HEALTH POLICY PROJECT, *supra* note 4.

The market approach involves several states moving to payment mechanisms, principally for Medicaid, that revolve around fixed unit prices for given diagnoses. Similar to the federal diagnostic related group (DRG) system of payment recently imposed by Medicare, state Medicaid programs are looking to the unit price system as a means of forcing hospitals to cut their costs or suffer financial loss in treating the Medicaid population. In a similar vein, some states have promoted health maintenance organizations (HMO's) as a means of reducing hospital utilization. In Wisconsin, for example, a plan to put state workers into HMO's has stimulated rapid development of similar organizations in the state.[108]

The final observation related to state hospital rate regulation regards the role of the federal government in the development of future state initiatives in this area. In the past, the federal government has encouraged state efforts at controlling the hospital marketplace principally through Medicare waivers. As mentioned, under this authority the federal government cedes to certain rate-setting states the power to establish the rate at which Medicare pays hospitals for treatment of the Title 18 population. Currently, however, continuation of the waivers in the four states that qualified seems tenuous,[109] and the granting of new waivers, although recently encouraged by Congress, seems less and less likely under the current Administration. Fundamentally, the Reagan Administration has opposed Medicare waivers on the basis that they encourage regulatory solutions to social problems and represent the inevitable expansion of government.

In response, several new state rate-setting laws, such as that of Maine,[110] eliminate the need for Medicare participation in the regulatory scheme. Thus, Medicare is "carved out" and does not participate in the otherwise all-payer nature of the system. As a result, hospitals treating Medicare beneficiaries must operate within the DRG payment limits for these patients, while all other payers operate at the rates established by the state. Under this system, Medicare cannot participate in savings that accrue to other payers, and hospitals might make substantial profits from the Medicare population, at least in the initial years of the federal DRG system. Increasingly states will attempt to avoid bringing the federal government into their plans for controlling hospital costs both because the federal government is hostile to such state initiatives (something of an irony given the interest the current Administration has in state participation in other issues), and because the states are discovering that the systems can operate adequately without Medicare participation.

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[108]*See generally* Andreano, *Wisconsin Health Care Reforms Blend Tighter Regulation and Competition*, BUS. & HEALTH, Jan./Feb. 1984, at 47.

[109]*See* Washington Report on Medicine and Health, Oct. 29, 1984, at 38.

[110]ME. REV. STAT. ANN. tit. 22, § 381 (West Supp. 1986).

V. Afterword

What makes for success in the legislature has little to do with successful administration of its product, namely, a policy initiative embodied in statute. If the legislative effort is to yield a successful solution to the ultimate problem, the statutory scheme and the legislative intent must be transformed into a properly functioning agency and program. Necessarily, the legislature must enact statutes that embody the best contemporary thinking about the problem and its solution.

However, the best laws do not assure an acceptable solution to the problem. A good example of the difference between statute and performance exists in the comparison of the Maryland and Washington statutes and their success in containing hospital costs. The Maryland statute was enacted in 1971 and provided for comprehensive control of all hospital budgets in the state.[111] Shortly after its enactment, the Washington legislature passed a bill[112] modeled on the Maryland law, incorporating all of the features of the Maryland drafters. After a decade of experience, Maryland's agency was able to point to statistically significant reductions in hospital cost inflation and overall budgets,[113] while no significant effect on costs was discernible in Washington throughout the period.[114]

The absence of effect in the one state and success in the other suggest only that the system envisioned in the law itself is not the controlling essential. It merely points up the importance of several factors which are necessary to make hospital cost control a reality. The first, obviously, is continuing commitment on the part of the legislature to the importance of the issue. Second, once the delegation by the legislature is complete, the more important factor is the support of the state's executive. Continuous reinforcement by the governor is necessary if the agency is to be protected from the enormously powerful political forces concerned with the administration of the regulatory system. Third is the independence of the agency; good appointments by the governor and insulation from political pressure are requisites for an effective implementation of the legislature's intention. Finally, and of overwhelming importance, is the presence of a strong and professional staff for the

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[111]1971 Md. Laws 627 (codified as amended at Md. Health-Gen. Code Ann. §§ 19-201 to 19-220 (Supp. 1985)).

[112]1973 Wash. Laws ch. 5 (codified as amended at Wash. Rev. Code Ann. §§ 70.39.030-70.39.910 (West 1975 & Supp. 1986)).

[113]Coelen & Sullivan, *An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures*, Health Care Fin. Rev., Winter 1981, at 1; Cohen & Colmers, *ReViews: A State Rate-Setting Commission*, 1 Health Aff. 99 (1982). *But see* Mitchell, *Issues, Evidence, and the Policymaker's Dilemma*, 1 Health Aff. 84 (1982).

[114]*Cf.* Coelen & Sullivan, *supra* note 113.

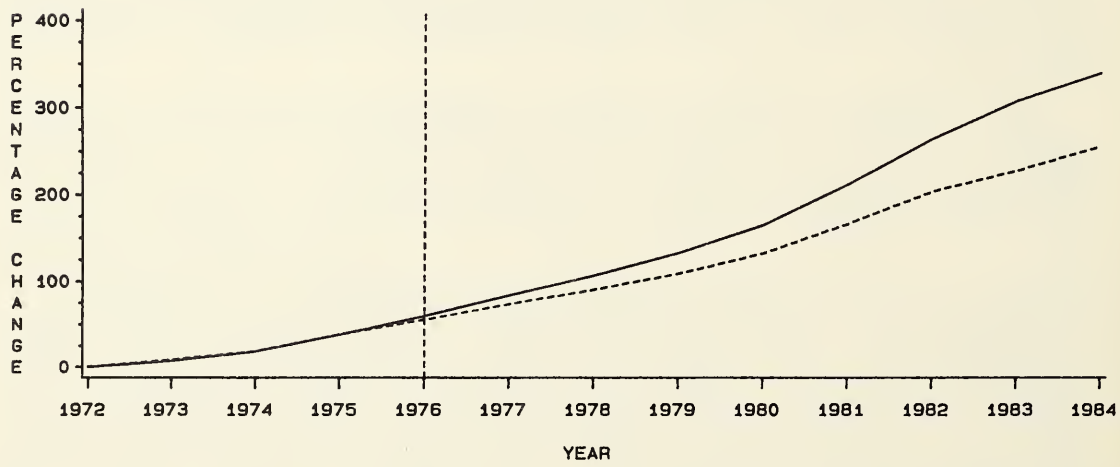
agency. Without a skilled and politically neutral staff, the rate-setting experiment will not succeed.

The foregoing analysis underscores the observation of one analyst that "good people cannot make a bad law work, just as bad people cannot make a good law work." Good laws are necessary to give force to a strong rate-setting program, and public-spirited people of determination must be encouraged to administer the will of the people as expressed through the legislature.

APPENDIX

FIGURE 1.

PERCENTAGE CHANGE SINCE 1972
IN EXPENSE PER ADMISSION (ADJUSTED)



LEGEND: ---- MEAN REGULATED 6 —— MEAN NONREGULATED 45

JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT

FIGURE 2.

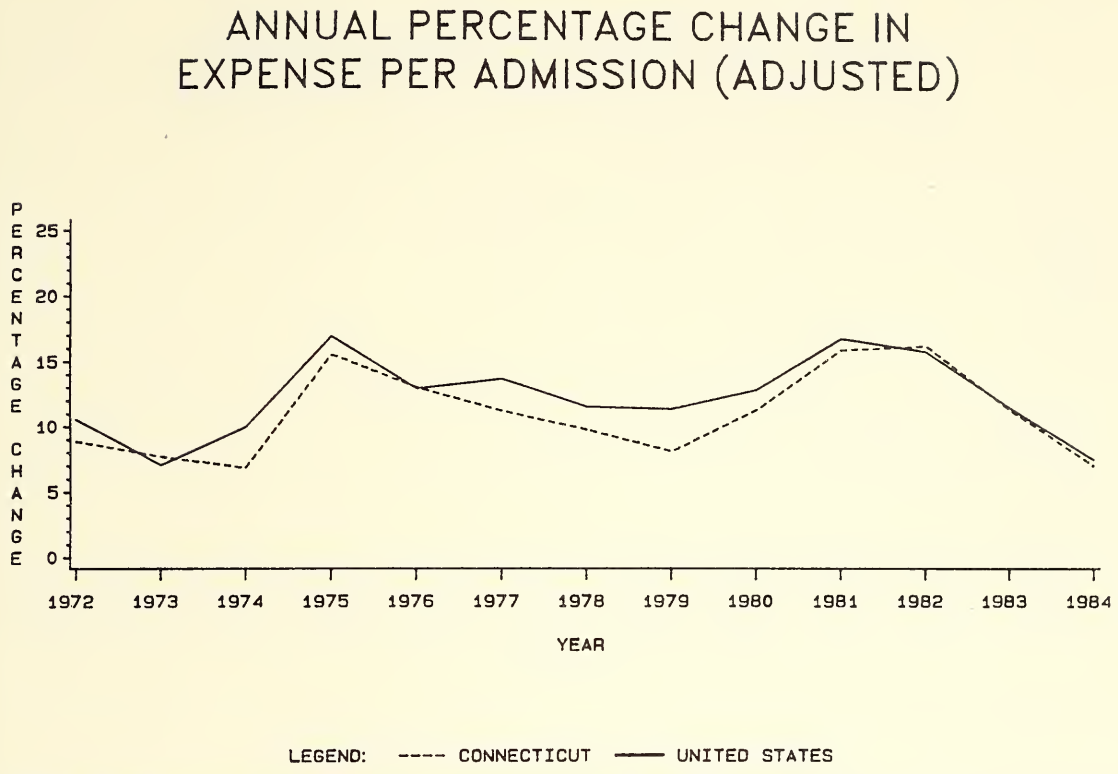


FIGURE 3.

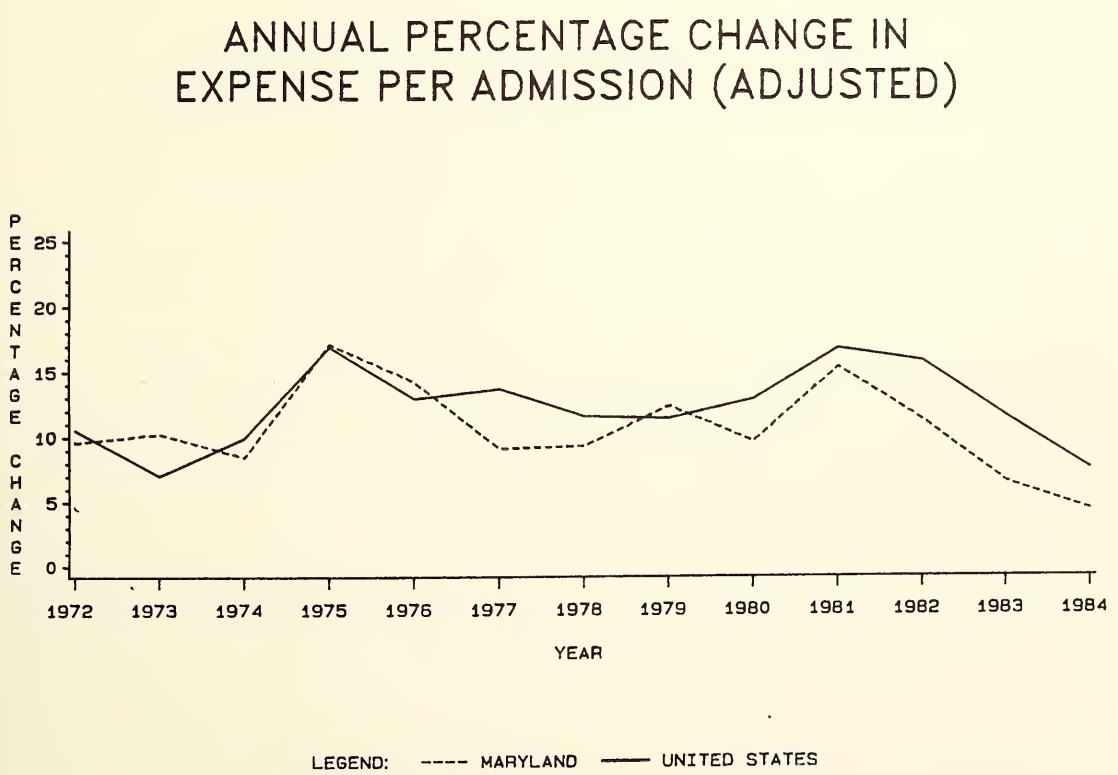


FIGURE 4.

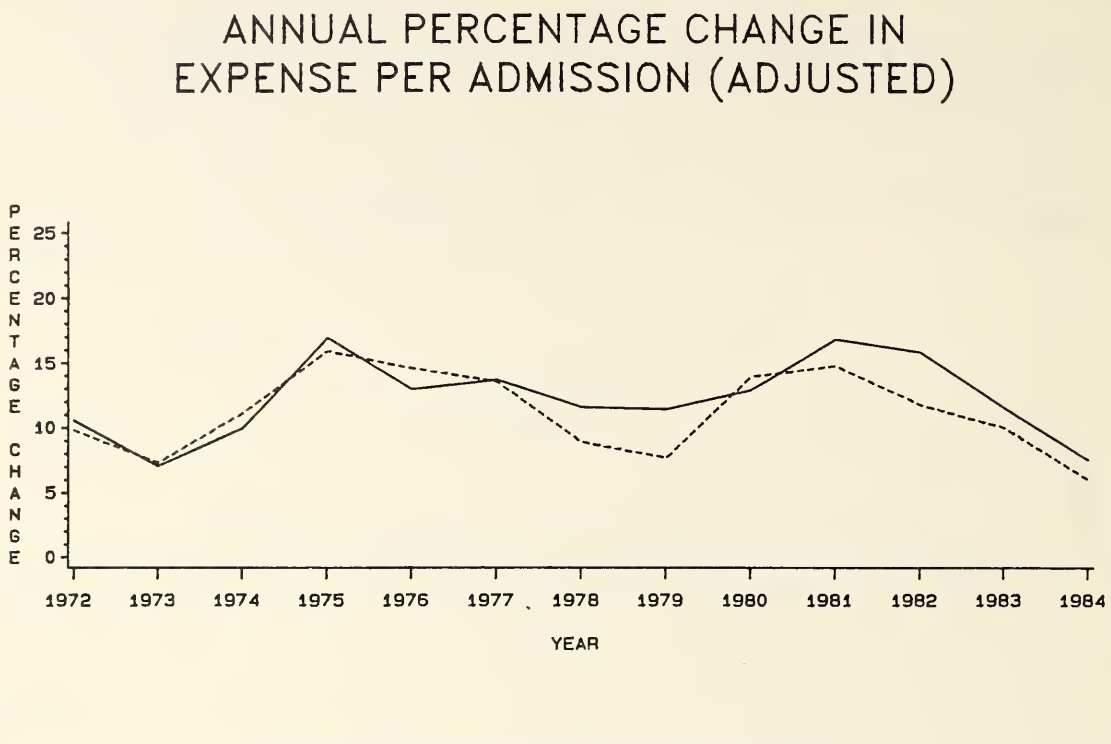


FIGURE 5.

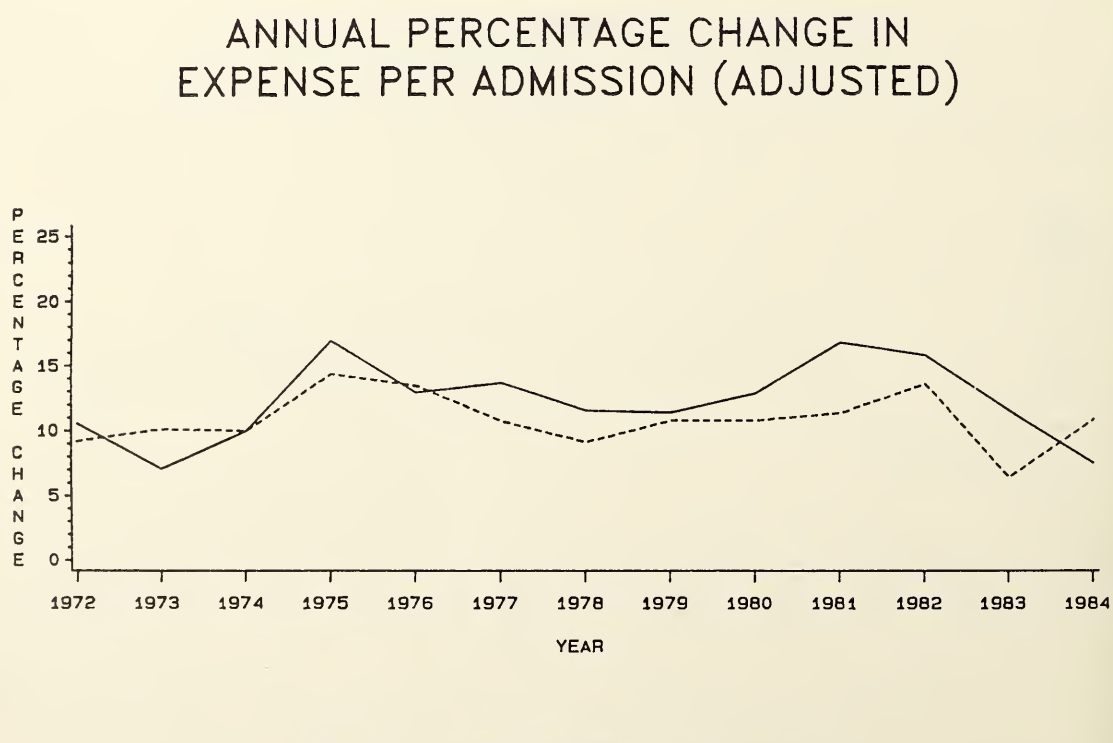


FIGURE 6.

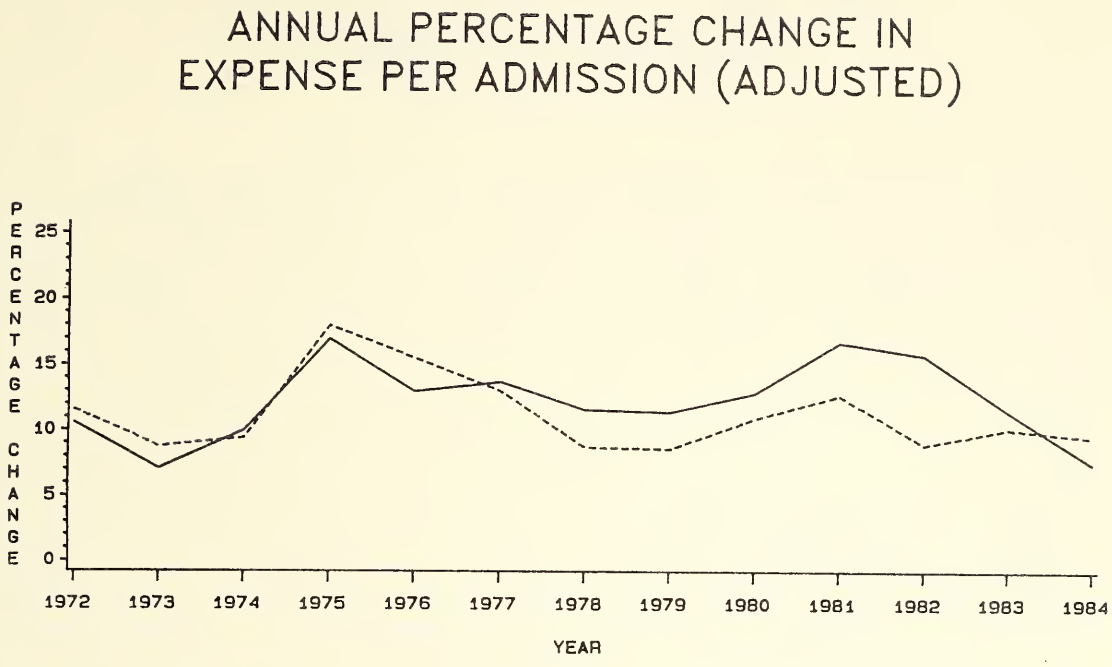


FIGURE 7.

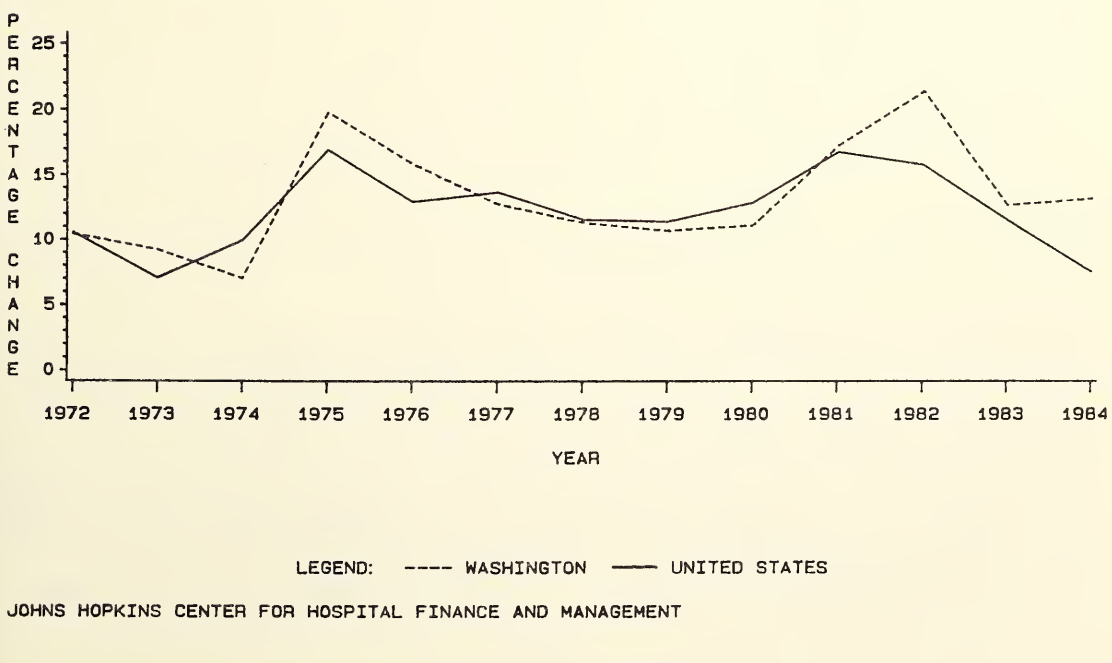
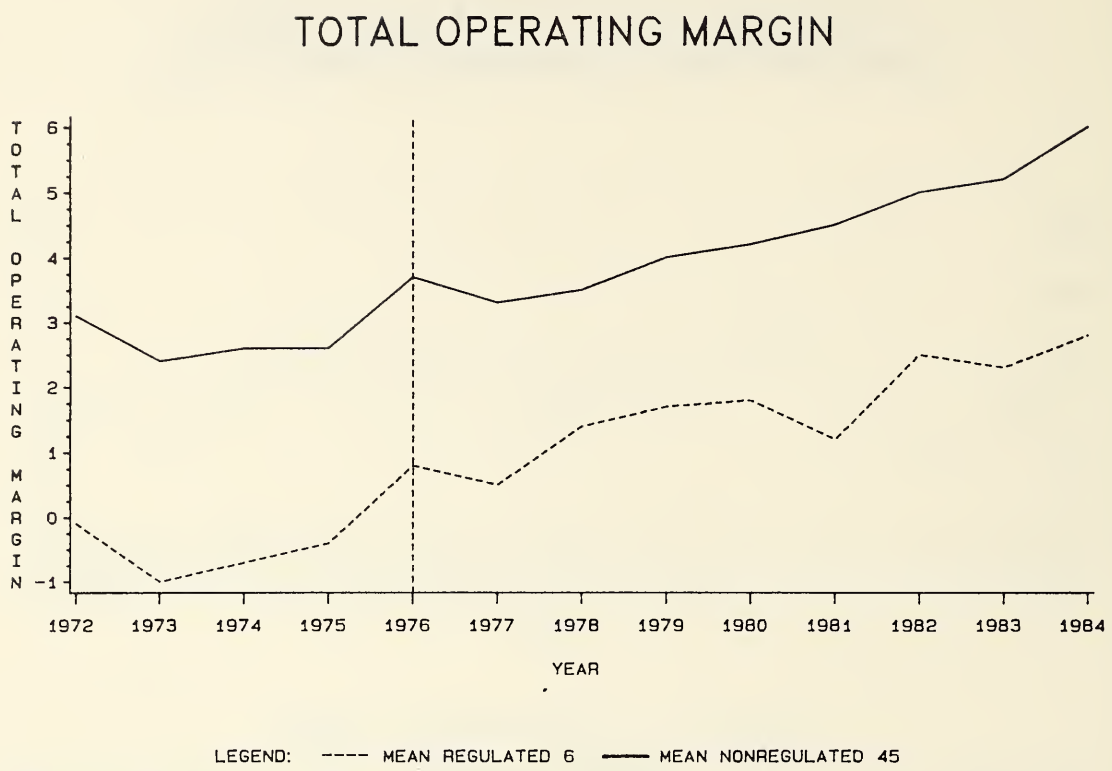


FIGURE 8.


TOTAL OPERATING MARGIN
TOTAL OPERATING MARGIN
6
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1972
1973
1974
1975
1976
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1979
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1981
1982
1983
1984
YEAR
LEGEND: ---- MEAN REGULATED 6 —— MEAN NONREGULATED 45
JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT