Health Cost Containment and Efficiencies
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Equalizing Health Provider Rates

All-Payer Rate Setting

Cost Containment Strategy and Logic

All-payer rates are payment rates that are the same for all patients who receive the same service or treatment from the same provider. "All payers" include patients, private health insurance plans, large employer self-insured plans and people without insurance; it also may include Medicaid and Medicare (under an approved waiver from the federal government). Rates may be set per service or per case (e.g., hospital care for a heart attack). Rate setting has mainly been used for hospital inpatient and outpatient services.

Under a system of all-payer rates, the reimbursement a provider receives for a given service is the same regardless of who pays. Different payers would not pay different rates for the same service, as is the case today. Currently, although virtually all patients are charged the same amount on paper (i.e., list price), actual payments vary widely based on negotiated discounts. A hospital, for example, may receive reimbursements from more than a dozen different health insurers and health plans, each with its own payment schedule. In addition, Medicare and Medicaid have their own rules for paying hospitals. Minnesota has described all-payer rates as a pricing system in which "charge = price = reimbursement."[1]

The two types of all-payer rate programs are:

- State-determined rates. This is the traditional approach to rate setting under which a state authority sets rates, most often for hospital services. It is similar to public utility regulation.
- Provider-set rates. This approach, which is sometimes called "uniform pricing," allows providers to set their own rates but requires rates to be the same for all payers. A state can establish rate setting parameters but does not set the actual rates. A variation of this approach applies only to uninsured patients who are not eligible for charity care. In this case, providers are prohibited from billing uninsured patients more than Medicare or health plans that have negotiated discounted rates.

Both approaches are designed to contain health care costs by fostering price competition and reducing or eliminating the cost to negotiate and administer multiple reimbursement schedules with multiple payers. State rate setting programs also reduce costs by limiting payment rates to the minimum necessary to cover a provider's operating expenses.

> Evidence is mixed, but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily curb overall cost growth.

Interest in all-payer rates as a cost containment tool declined significantly since its heyday in the 1970s, but all-payer rate setting and uniform pricing have received renewed attention for several reasons.

- In recent years, mergers and acquisitions have led to increased hospital and health care system market concentration. According to one health policy expert, the disproportionate bargaining power providers have in markets where they are dominant makes cost control extremely difficult.[2] All-payer rate setting addresses this problem.
- Health care costs continue to increase much faster than general inflation. Frustrated by the apparent inability of the market (including managed care) to control spiraling health care costs, policymakers want to improve market competition by making it easier for health care purchasers to compare prices. They also want to reduce administrative costs associated with multiple, complicated reimbursement schedules.
- More sophisticated data systems, advances in health information technology and improvements in risk-adjustment methodologies make it easier to set rates that accurately reflect provider costs and include incentives for cost containment.

In addition to cost containment, other reasons exist for renewed interest in all-payer rates.

- Advocacy groups are concerned about "discriminatory pricing"—the practice of billing full charges ("list price") to uninsured patients who are not eligible for charity care. These charges often may be at least twice those of commercially insured or Medicare patients.
- Providers are concerned about the disproportionate bargaining power large health insurers have in some states, particularly where one or two insurers dominate the market.

Target of Cost Containment

The primary target of all-payer rates are uneven and high health care prices, especially for inpatient and outpatient hospital care. Numerous studies show the main reason per capita health care expenditures are so much higher in the United States than in other countries is higher medical prices.[3] Between January 1988 and January 2009, the consumer price index (CPI) rose 82 percent, while the medical component of CPI rose 175 percent.

All-payer rates are intended to promote provider price competition, reduce health plan and administrative costs and, when combined with quality incentives, reward high quality/low cost providers. All-payer rates also are designed to address significant mark-ups in provider charges that, in the current system, are needed to cover deeply discounted rates for some payers. Hospital mark-ups average 187 percent of costs and range as high as 400 percent of costs.[4]

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, creates a Center for Medicare and Medicaid Innovation (CMI).[5] The act directs CMI to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care. It allows states to test and evaluate systems of all-payer payment reform for the medical care of residents of the state, including individuals who are eligible for both Medicare and Medicaid. In selecting models to test, the Secretary of Health and Human Services must give preference to models that improve the coordination, quality, and efficiency of health services.

State Examples

- Maryland established an all-payer hospital rate setting program in 1971 that still operates today.[6] The program's goals include constraining hospital costs; providing financial stability for hospitals; providing efficient and effective care; and financing growing levels of hospital uncompensated care. The program is administered by the Health Services Cost Review Commission, a government agency with broad authority to set hospital rates. The rates take into account each hospital's reasonable costs, level of charity care and severity of patient illness. They also include quality and efficiency incentives. The commission sets only hospital rates, not physician fees. Maryland's rate-setting program applies to fully insured and employer self-funded health plans, Medicaid and, under a federal waiver, Medicare. Rates are set per-diagnosis (e.g., all hospital care for a pancreas transplant, as opposed to per-service, separate charges for sutures, ultrasound, etc.) to encourage hospitals to control the cost of each episode of care.

- A Minnesota provision in comprehensive 2008 health reform legislation calls for creation of a work group to make recommendations on "the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers."[7] The work group has developed an "evolving concept of uniform pricing in practice" that includes three elements, cited in its report as:
  1. Services (individual and bundled) are defined.
  2. Providers set an accepted reimbursement payment price. There is no requirement about how prices are set; each provider could offer a different price.
  3. Price = payment = what insurance plan pays + what the consumer pays.[8]

- Oregon does not have an all-payer rate system but is considering limits on provider rate increases that would apply to all payers. The Oregon Health Fund Board, established by the Oregon legislature in 2007,[9] issued a November 2009 report that examined a number of health care reform strategies, including "authorization of an appropriate state agency to establish annual maximum limits ("ceilings") on price increases charged by health care providers in a similar class (e.g., licensed health care facilities)."[10] It suggested two ways to establish ceilings: limit increases to a fixed multiplier of the Medicare reimbursement rate (e.g., 130 percent) or limit them to no more than a fixed percentage from a base year (e.g., consumer price index + 1 percent).

- Massachusetts examined potential savings from of a variety of cost containment strategies, including a rate setting program similar to Maryland's. An independent report estimated hospital all-payer rate setting could reduce health spending in Massachusetts by between 0.1 percent and 3.9 percent between 2010 and 2020.[11] Rate setting ranked second, behind global payments, in its predicted ability to save costs. (A global payment is a fixed prepayment made to a group of providers or a health care system that covers most or all of a patient's care during a specified time period; global payments are discussed in another brief in this series.)

- To bring them more in line with other payers' rates and make care for the uninsured more affordable, several states have capped the rates hospitals can charge uninsured individuals. Although the caps do not establish all-payer rates, they move a step closer to rate equalization. A 2008 New Jersey law, for example, limits to 115 percent of Medicare rates the amount hospitals can bill certain uninsured patients.[12] The cap in Illinois is 135 percent of Medicare rates.[13] Massachusetts now requires hospitals to charge self-payers the same rates as third-party payers.[14] Under a 2005 agreement with Minnesota's attorney general, hospitals give the same discounts as insurance companies to uninsured Minnesota patients with annual family incomes under $125,000. According to a Families USA brief, "This can mean a 40 – 60 percent price reduction in services."[15]

- States are looking not only at the rates uninsured patients pay, but also at the rates they pay for their own programs.

  - Colorado legislation enacted in 2010 (SB 10-020) authorized CoverColorado—the state's high-risk pool for the uninsured—to set its own health provider reim-

bursement rates instead of paying commercial rates. A 2008 report to the Colorado General Assembly noted that the program could save millions of dollars by moving to a fee schedule based on a multiplier of Medicare rates.[16]

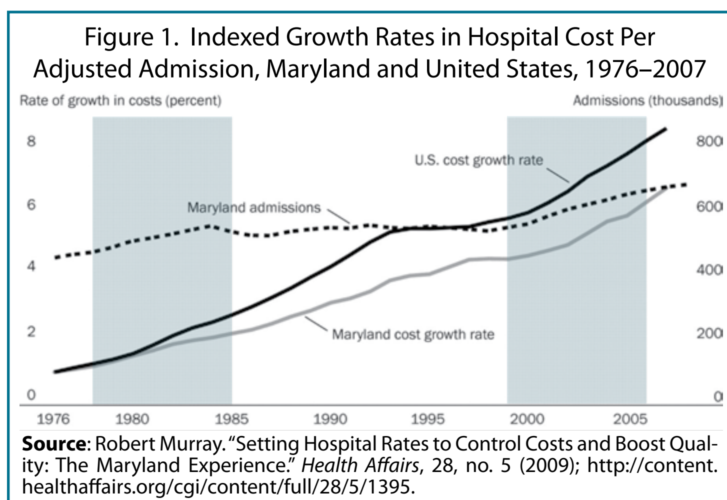
- A February 2010 North Carolina state audit found that, on average, providers of inmate hospital services bill the Department of Correction 4.5 times the applicable Medicare/Medicaid reimbursement rates.[17]

Evidence of Effectiveness

Evidence is mixed but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily curb overall cost growth. It also suggests state rate-setting can be administratively complicated, difficult to sustain and, in some cases, politically unpopular. Uniform pricing strategies that allow providers to set all-payer rates are too new to assess their effect on costs.

- Evidence shows Maryland's rate setting program has consistently held hospital cost growth per admission to below the national average (Figure 1). Between 1976 and 2007, Maryland had the second lowest rate of increase in costs per admission in the country. According to the executive director of the Maryland Health Services Cost Review Commission, "Had Maryland costs grown at the national rate from 1976 to 2007, hospital spending would have been cumulatively $40 billion higher than what resulted under rate setting."[18]

Figure 1. Indexed Growth Rates in Hospital Cost Per Adjusted Admission, Maryland and United States, 1976–2007



Source: Robert Murray. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs*, 28, no. 5 (2009); http://content.healthaffairs.org/cgi/content/full/28/5/1395.

Maryland attributes its success controlling per admission costs to several factors. They include the Health Services Review Commission's broad statutory authority that allows flexibility in its approach to cost control; the state's Medicare waiver; and the commission's political, legal and budgetary independence.[19] Although Maryland has slowed per admission cost growth, the same cannot be said for the growth in admissions, outpatient visits or overall spending per capita. In large part this is because, as with other hospital rate setting programs, Maryland does not control admission rates. To address this problem, the Cost Review Commission is instituting pay-for-performance incentives and episode-based hospital rates (discussed in other briefs in this series) to encourage reductions in both hospital use and costs.

- Evidence exists that rate setting can "temper excessive use of cost-increasing technologies" but does not reduce their availability.[20]

- At one time, more than 30 states had hospital rate setting or budget review programs. By 1990, most had been discontinued, and Maryland is the only state that still has a program. Several factors contributed to the dismantling of rate setting programs. Among them were the increased use of managed care to control costs; growing hospital dissatisfaction with the rate-setting process; a public policy shift from a regulatory to a more market-oriented approach to cost control; mixed cost containment results; and the inability to sustain reductions in cost growth over the long term, even in states where efforts were initially successful.[21]

- A 2009 RAND Health report examined the literature on states' experiences with hospital rate setting programs during the 1970s and 1980s.[22] It found mixed evidence of cost savings. Some studies reported as much as a 2 percent annual reduction in hospital spending growth in certain states; most studies found no effect. At least one study suggested rate setting may actually have increased per capita spending in some states. Where cost growth reductions occurred, evidence suggests that, in most cases, it may not have been sustainable.

Challenges

Establishing an effective program of state-determined or provider-set all-payer rates presents a number of challenges.

- Medicaid and Medicare may resist participating. Medicaid programs may be concerned that an all-payer rate program will increase their reimbursement rates. Medicare will not participate unless a state can demonstrate that Medicare's costs will not increase more rapidly under all-payer rates than they would if Medicare did not participate.

- To slow overall cost growth, states need to control not only health care prices but also health care use (i.e., the volume and intensity of health services).

- Where all-payer rates apply to one type of health care provider only (e.g., hospitals), care—and thus the costs of care—may simply be shifted to other providers (e.g., free-standing surgery centers).

- Provider-set all-payer rates will not spur price competition unless there is a place (e.g., a website) where purchasers can compare providers' rates not only for individual services but also for the total cost of care for a condition (e.g., knee replacement surgery).

- State all-payer rate setting programs present additional challenges. Some major challenges are listed below.

  - Setting appropriate rates is difficult. They must be set to avoid incentives for providers to provide too many or too few services and ensure financial viability without paying for inefficient care.

  - Presently, there appears to be little support for a highly regulated rate-setting structure.[23] Instead, the focus is on payment incentives to improve quality and efficiency and on organized systems of care that can manage total patient care costs.

  - The cost to operate a rate-setting system can be substantial. Maryland's hospital rate setting program has 30 staff and a $4.9 million annual operating budget.

For More Information

Eibner, Christine, et al. *Controlling Health Care Spending in Massachusetts: An Analysis of Options.* Washington, D.C.: RAND Health, August 2009. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

McDonough, John E. "Tracking the Demise of State Hospital Rate Setting." *Health Affairs* 16, no. 1 (January/February 1997). http://content.healthaffairs.org/cgi/reprint/16/1/142.pdf.

Murray, Robert. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs* 28, no. 5 (2009). http://content.healthaffairs.org/cgi/content/full/28/5/1395.

Future Updates

The latest information on this topic is available in an NCSL online supplement at www.ncsl.org/?tabid=19928.

Notes

1. Uniform Claims Review Process Study, "Uniform Pricing Discussion," Meeting Notes (St. Paul: Minnesota Department of Health, June 29, 2009), http://www.health.state.mn.us/healthreform/claims/MeetingNotes_090629.pdf.

2. Joseph White, *Cost Control and Health Care Reform: The Case for All-Payer Regulation* (Cleveland: Case Western Reserve University, May 12, 2009), http://www.ourfuture.org/files/JWhiteAllPayerCostControl.pdf.

3. See, for example, G.F. Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003), http://content.healthaffairs.org/cgi/reprint/22/3/89.pdf.

4. Elena Conis, "Impact of a State-Level All-payer System," *Health Policy Monitor* (October 2009), http://www.hpm.org/survey/us/a14/5.

5. U.S. P.L. 111-148. Part III—Encouraging Development of New Patient Care Models, Section 1115A.

6. Md. Health Code Ann. §19-200 (1971).

7. 2008 Minn. Laws, Chap. 358.

8. Uniform Claims Review Process Study, "Uniform Pricing Discussion."

9. 2007 Or. Laws, Chap. 697.

10. Oregon Health Fund Board, *Aim High: Building a Healthy Oregon—Final Report* (Salem, Ore.: Oregon Health Fund Board, November 2008), http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf.

11. Christine Eibner et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options* (Washington, D.C.: RAND Health; August 2009), http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

12. N.J. Rev. Stat. § 26:2H-12.52 (2008).

13. 2008 Ill. Laws, P.A. 95-0965.

14. 2006 Mass. Acts, Chap. 324.

15. Families USA, "A Pound of Flesh: Hospital Billing, Debt Collection, and Patients' Rights," *Issue Brief* (Washington, D.C.: Families USA, March 2007). http://www.familiesusa.org/assets/pdfs/medical-debt.PDF.

16. CoverColorado Long-Term Funding Task Force, *Final Report to the Colorado General Assembly* (Denver: CoverColorado, March 31, 2009), https://www.covercolorado.org/downloads/CoverColorado-Task-Force-Final-Report.pdf.

17. North Carolina Office of the State Auditor, *Department of Correction Fiscal Control Audit* (Raleigh: Feb. 11, 2010), http://www.ncauditor.net/EPSWeb/Reports/FiscalControl/FCA-2009-4500.pdf.

18. Robert Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," *Health Affairs* 28, no. 5 (2009), http://content.healthaffairs.org/cgi/content/full/28/5/1395.

19. Robert Murray, "Setting Hospital Rates To Control Costs and Boost Quality."

20. Kim Sutherland and Sheila Leatherman, *Regulation and Quality Improvement: A Review of the Evidence* (London: Health Foundation, October 2006), http://www.health.org.uk/publications/research_reports/regulation.html.

21. John E. McDonough, "Tracking the Demise of State Hospital Rate Setting, *Health Affairs* 16, no. 1 (January/February 1997), http://content.healthaffairs.org/cgi/reprint/16/1/142.pdf.

22. Christine Eibner et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, 50-53.

23. The Heller School for Social Policy, "Health Care Cost Management in Massachusetts: A Discussion of Options, Meeting #7: State Regulatory Strategies," Conference Report (Waltham, Mass.: Brandeis University, Sept. 5, 2009), http://heller.brandeis.edu/costmanagement/meeting-material/090508/conference_report.pdf.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

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