2015

All Payer Hospital Regulations

Sam Lovejoy

Heath Ashford

William K. Willis
Marshall University, willis23@marshall.edu

Alberto Coustasse
Marshall University, coustassehen@marshall.edu

Recommended Citation
Lovejoy, S., Ashford, H., Willis, W. & Coustasse, A. (2015). All payer hospital regulations. Business and Health Administration Proceedings. Deborah Gritzmacher, Editor, p. 42-49.

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Sam Lovejoy
Healthcare Administration Student
Healthcare Management
College of Business
Marshall University
100 Angus E. Peyton Drive
South Charleston, WV 25303
lovejoy2@live.marshall.edu

Heath Ashford
Healthcare Administration Student
Healthcare Management
College of Business
Marshall University
100 Angus E. Peyton Drive
South Charleston, WV 25303
ashford3@live.marshall.edu

William Willis, DrPH, MSHA
Assistant Professor
Health Care Administration Program
College of Business
Marshall University Graduate College
100 Angus E. Peyton Drive
South Charleston, WV 25303
(304) 746-8946
(304) 746-2063 FAX
willis23@marshall.edu

Alberto Coustasse, DrPH, MD, MBA, MPH
Associate Professor
Health Care Administration Program
College of Business
Marshall University Graduate College
100 Angus E. Peyton Drive
South Charleston, WV 25303
(304) 746-1968
(304) 746-2063 FAX
coustassehen@marshall.edu

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Sam Lovejoy, Marshall University
Heath Ashford, Marshall University
William Willis, Marshall University
Alberto Coustasse, Marshall University

ABSTRACT

Introduction: *An all-payer system is a price setting system where rates of payment for healthcare services have not been negotiated between a hospital or health system or a payer but instead by a third party organization, such as Maryland's Health Services Cost Review Commission (HSCRC), who sets most hospital rates that all payers agree to honor. All payer hospitals focus is on legislative principles in an effort to control costs.*

Methods: *The methodology for this study was a literature review compiled with overview of All-payer hospital systems and its utilization in a hospital setting. All articles prior to 2000 were eliminated from the search. Twenty-eight references were examined and concluded to have mitigated the inclusion parameters along with benefits and disadvantages of the system.*

Results: *Since 1976 Maryland has successfully kept hospital costs under control using an all-payer system. Additionally, improvements in length of stay and other health measures have improved. While an all payer system works for Maryland that has a large population in urban areas, other states may not see an improvement if they are larger or more rural. Even with lower controlled rates, Maryland still ranks less favorably in per capita health spending and regional variations than other states.*

Discussion/Conclusion: *The majority of states are not utilizing the benefits of all payer systems. Implementation can improve healthcare in the US by impeding escalating costs, distinguishing fair payment systems, and increasing the access to care. This research study did not extensively compare other nations all payer systems to Maryland or how it could be implemented in the US. The all payer system has practical implications in the US healthcare system. If programs to cut spending are implemented too quickly, national healthcare could be compromised.*

Key Words: *All Payer Hospitals, All Payer Hospital Regulations, All Payer Healthcare systems*

INTRODUCTION

For nearly four decades, Maryland hospitals have operated under a state regulated, all-payer system that no other state has been able to successfully replicate (Kastor & Adashi, 2011). An all-payer system is a price setting system where rates of payment for healthcare services have not been negotiated between a hospital or health system and a payer but instead by a third party organization, such as Maryland's Health Services Cost Review Commission (HSCRC), who sets most hospital rates that all payers agree to honor (Wagner, 2011). California has been considering all-payer rates in the face of escalating health care costs (Berenson, Ginsburg, & Kemper, 2010). Massachusetts whose state healthcare reform was initiated by Governor Mitt Romney is also considering an all-payer system to help contain costs (Kingsdale, 2009). New Jersey enacted fixed payment rates for hospitalization in the 1970s, but rescinded its all payer rate setting in 1992. Initially rates were based on diagnosis related with a surcharge added to compensate for indigent care. When Medicare refused to pay the state established rates, the policy was abolished (Saha, 2006). Japan is an example of a country that has completely gone to an all payer fee schedule (Ikeda, 2004). Reversing the trend, the Netherlands has abolished its' all payer system to a system where prices are negotiable (Halbersma, Mikkers, Motchenkova, & Seinen, 2011). A major reason the United States may want to consider its own national all payer fee schedule is it will help contain costs of Medicaid and Medicare, keeping their rates in line with commercial carriers (Newhouse, 2010). While all-payer hospitals have provided many benefits and advantages for their patients, there are a few negative effects to these types of hospitals as well (Spencer, Gaskin, & Roberts, 2013). Patients with private insurance had lower mortality rates when risk adjusted as compared to Medicare patients. Difference in outcomes may be contingent upon primary care physician referral to a hospitalist or a surgeon rather

than type of insurance. Due to Maryland's unique market, few states have been able to implement its model. Maryland has favorable political support, appropriate markets, and dedicated administrators which has lead to its ultimate success (Murray, 2012). In addition while HSCRC can control hospital policy to a certain degree, the commission has minimal influence upon physicians' attitudes (Pauly & Town, 2012). All payer hospitals focus is on the legislative principles that gave the system its initial purposes. In an effort to control costs, rate setting for services provided were adopted in 1974 by the HSCRC in its efforts to achieve these goals (Cohen,2008).

The HSCRC is governed by seven commissioners appointed by Maryland's governor. They established hospital-specific and service specific rates for all inpatient, hospital-based outpatient, and emergency services (Murray,2009). The first and foremost goal of the HSCRC has been cost containment. An increased access to care has been deemed to be the second major goal of the HSCRC. The third goal of having an equitable, fair payment system has prohibited the so-called cost shifting that takes place in other states. The final two goals are transparency and accountability (Buntin, 2011). Prior to HSCRC full implementation of all payer system in 1976, Maryland's adjusted cost for each admission was higher than the national average by 26%. While in 2009, Maryland's average admission cost rose by 2% compared to the national average of 4.5% (Kastor & Adashi, 2011). In addition, Maryland has adapted two pay for performance programs which have improved outcomes and reduced hospital variations in provided care. Examples include improved influenza vaccination by 20.5% (71.5% to 92%) from 2007 to 2010. Hospital acquired conditions decreased by 15.3% with an estimated savings of $110.9 million over a two year period beginning in 2008 (Calikoglu, 2012).

Among the concerns for equity have been financing uncompensated care and spreading the costs across all payers, reducing the difference between hospital charges and costs, and rescuing hospitals on the brink of bankruptcy (Berwick & Hackbarth, 2012). These goals represent a fundamental shift in the role of state rate setting; as a result, broader outcome measures are required to determine their overall impact. The state of Maryland has saved approximately $43 billion since 1976 while improving access to healthcare. However, Maryland hospitals are not always as profitable as hospitals in other states, resulting in decreased margins and increased debt for Maryland's hospitals (Wagner, 2011).

The purpose of this research project was to analyze the background and definition of All-payer hospital systems, to review the application of these systems in healthcare and to explore both benefits and barriers of this system to determine the impact on the US health care system.

METHODOLOGY

The methodology for this study was a literature review compiled with overview of All-payer hospitals and its utilization in a hospital setting. Electronic databases of EBSCOHost, Science Direct, PubMed, and Google Scholar were searched for the terms 'All Payer Hospitals' or 'All-Payer Hospital Regulations' or 'All Payer Health Care systems' and "Benefits" or "disadvantages". Only articles that were written in English were included for review. To ensure that the research was current, all articles prior to 2000 were eliminated from the search. Twenty-eight references were examined and concluded to have mitigated the inclusion parameters if material provided accurate information about All Payer Hospitals along with benefits and disadvantages of the system. This search was completed by HA and SL and validated by AC.

The template for the research was structured predominantly by comparing the benefits to the barriers. The authors propose that the benefits of all payer hospital system outweigh the barriers.

Insert Table 1

RESULTS

Since 1976, Maryland has successfully kept hospital costs under control compared to the rest of the country, thus meeting the HSCRC main goal of controlling costs (Kastor & Adashi,2011). Hospital costs per admission in Maryland in 1974 were 24% above the national average. By 1992, hospital costs per case had fallen to 11% below the national average and by 2005 had fallen to 5% below the national average (Maryland Hospital Association, 2007)

Length of stay is one variable that impacts overall cost and savings. Since 1976, length of stay in Maryland has been reduced over 49 %, from 8.5 days to 4.3 days as of June 2005. While national percentages have decreased as well, Maryland's improvement is significant, from 12% above the national average in 1977 to 16% below the national average in 2004 (Maryland Hospital Association, 2007). The state of Maryland has two pay for performance programs. The first is a quality based reimbursement program similar to Medicare. A separate program compares hospitals' risk adjusted relative performance on hospital acquired conditions (Calikoglu, 2012). While payers are eager to utilize pay for performance systems, there are mixed results suggesting there is no improvement in the quality of care obtained (Gonzalez, Penson, Kosiak, Dupree, & Clemens, 2007). Maryland has focused on quality and metrics linking them directly to the payment system, similar to the Affordable Care Act (White,2009). The legislature has viewed access to health care as a right of all Maryland citizens and the provision of that care a societal responsibility of all hospitals. Therefore, the HSCRC was required to establish a way of paying for care to the uninsured and to do so in a reasonable, equitable, and transparent way. First, the HSCRC is a politically independent agency, so it can set rates without undue discrimination or preference to any payer. Second the legislature believed that patients should pay only for the cost of their own care, not the care provided to other patients (no cross-subsidization or cost shifting). Because of the All-Payer system, the HSCRC established rates for the hospital services. These rates reflected a mark-up of 18% that included a provision for providing for uncompensated care. Because hospitals in the state of Maryland know they will be reimbursed for uncompensated or charity care, hospital rates are the same whether a patient has insurance, does not have insurance or any brand of insurance, private or federally funded (Zhang, 2009) . Patients and payers pay for the care they receive and also their fair share of social costs in the system. Third, the legislature intended that all payers and patients should pay their fair share of hospital costs, including uncompensated care (Murray, 2009). The legislation creating HSCRC gave it the power to set rates prospectively each year that all insurers would pay to the acute care hospitals in the state, making Maryland for all intent and purposes, an all-payer state. Maryland has been the only state with a federal waiver that effectively transferred hospital rate control for Medicare and Medicaid recipients from the Federal government to a state commission (Kastor & Adashi, 2011).

The HSCRC is an independent entity that operates alone and is not confined to Maryland's state general fund (Murray, 2009). Most stakeholders, hospitals, payers, and patients favor the system. Hospitals appreciate transparency and equity of the rate setting process, the enhanced compensation by public payers, and the elimination of protracted rate negotiations with each payer. Payers value the clarity and parity of the HSCRC approved hospital rates, the absence of hospital driven cost-shifting, and the containment of continually increasing costs. Patients have welcomed the ability to obtain adequate care. The hospital closure rate in Maryland has been at approximately the national average. Nationwide, hospital profits have been five to six percent whereas Maryland's profits have been in the three to five percent range since 1994. The All-Payer rate setting system affords the hospitals of the state of Maryland with an increased degree of financial predictability and stability. This fact alone has benefitted Maryland hospitals in their ability to access municipal bond markets and bond ratings (Cohen, 2008). Although as many as 30 states once regulated hospitals costs, by 1991, only Maryland continues to use an all-payer rate setting system (Kastor & Adashi, 2011). While reasons vary state by state, the fundamental reason for the decrease in the state rate setting systems has been federal policy (Kilbreth,2010). Another use of the HSCRC has been to incentivize hospitals to increase efficiency, such as when payments were increased in 2004 to reward hospitals based on the quality and efficiency in their Health care Information technology (HIT) systems, and the HSCRC funded a statewide survey of all HIT systems (Kazandjian & Lipitz-Snyderman,2011).

What makes the All payer hospital system interesting is that it is able to charge private and public payers equally despite if a payer is covered under the Medicare or Medicaid umbrellas respectively (Zhang, 2009; Murray ,2012). This transparency tactic of improved metrics also has provided a more cooperative approach and allows for more support between the system and the stakeholders such as the payers and hospitals. One major advantage of transparency is that all payer systems has bundled all major stakeholders under a common set of rules and set payment for each type of service provided under a system's care. In order for Maryland's all payer system to work, rules had to be implemented from a government standpoint in order to act as a lead innovator, not to allow hospitals to gouge patients with high prices, and the state has acted as a centrally governed body to achieve equal costs among stakeholders. After setting these equal costs for all stakeholders, a benefit is that all patients of different monetary backgrounds would be able to obtain and afford equal quality healthcare. These principles of the system have been in place to promote fairness into the system therefore making all stakeholders accountable in a public setting (Gaynor & Town, 2012).

There are disadvantages to All Payer Hospitals as well as indicated previously. The disadvantage of all payer system is that all states may not be able to implement this system effectively due to the managing care of certain patients in a larger geographical area as opposed to Maryland which is a relatively small state. States with greater rural areas would suffer because of increased uninsured or underinsured population in these areas. Worsening in mortality of the uninsured in New Jersey was related to decrease in aggressive services due to the market. Greater competition lead to increased pressure on hospitals to lower prices. In an attempt to reduce prices, patient care was altered to control costs associated with ultimate care (Volpp, Ketcham, Epstein, & Williams, 2005). Also, other states believe that regulations of health care costs is not the answer and that managed care, capitation, and diagnosis related groups would be a more effective way to implement cost containment of healthcare expenditures. Findings suggest that new prospective DRG all payor systems may be inequitable to certain groups of patients or various types of hospitals (Quentin, Scheller-Kreinsen, Blumel, Geissler, & Busse, 2013). Also, even with an all payer system, Maryland still ranks less favorably in per capita health spending and on regional variations than other states. Between 1979 and 2005, uncompensated care in Maryland rose from 5.8% of revenue to 8.0% of revenue and from $70,000,000 to $800,000,000 (Cohen , 2008). These increases are largely due to reductions in eligibility and coverage of the State's Medicaid program.

DISCUSSION

The cornerstone to the mission of most hospitals in the US is to provide care for residents of the community. Technically, this mission does not incorporate the ability to pay however fiscal responsibility dictates restraint. Because there are no public government run acute care hospitals in Maryland, the uninsured have access to all hospitals. The results of the all-payor system in Maryland have been cost containment, equity, prevention of cost shifting, access to care, accomplishment of social objectives, and solvency of efficient hospitals (Maryland Hospital Association, 2007). Lack of an all payer system leads to cost shifting. Cost shifting generates a system in which influential payers force weaker payers to cover a greater percentage of the fixed costs of healthcare (Ginsberg, 2010). In fact, in many states, Medicare is able to negotiate much lower prices knowing that the healthcare provider can make up the difference easily from private payers (Glazer & McGuire, 2002). Also, lack of an all-payer system has given large consolidated health care providers ability to offer less quality in care, but are able to use the size of their market share to negotiate higher payments from private payers (Ho & Hamilton, 2000).

By comparison, all payer system is a mechanism that better controls overall costs and provides equitable payment (Reinhardt, 2011). The HSCRC was the first state rate regulatory program to propose a system known as Guaranteed Inpatient Revenue (GIR), to address this issue. Prior to this system, hospitals had no incentive for restricting utilization. Quite the opposite, hospitals could improve their profitability by increasing length of stay or increasing utilization of other services, such as lab or x-ray. The GIR system set inpatient charges per admission. If hospitals exceeded their targets, they were penalized, but were permitted to keep all savings derived from decreasing utilization (Maryland Hospital Association, 2007). All payer regulations currently provide better cost control than evidence based medicine or pay for performance programs, though these programs show promise.

One problem with the current system is not that prices rise but they never decrease. In other markets such as computers, prices decrease with improved technology. The same analogy is not true in medicine. Examples are laser surgery for eyes or statins for elevated cholesterol (White, 2009). Maryland has been successful in regulating hospital unit price however price is only one variable of the equation (Kilbreth, 2010). Even Maryland has struggled to control total spending growth (Murray, 2012). While Maryland has reported saved over $43 billion since 1976, the all payer system has resulted in decreasing margins and increasing debt (Wagner, 2011).

One limitation of this research study was that it did not extensively compare other nations all payer systems to that of Maryland or how foreign systems could be implemented in the US.

The all payer system has practical implications in the US healthcare system. If programs to cut spending are implemented too quickly, healthcare to the population could be compromised. A better strategy would be to reduce waste. Categories of waste to be eliminated are inappropriate treatment, failure to coordinate care, reduce administrative cost, excessive markup, and abuse or full blown fraud.

CONCLUSION

Implementation of all payer hospital systems can improve healthcare in the US by impeding escalating costs, distinguishing fair payment systems, and increasing the access of care to patients. It can be crucial for healthcare organizations to take advantage of cost containment opportunities that all payer hospital systems provide to prevent cost shifting.

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Table 1 :Benefits and Barriers of All Payer Hospital System in Maryland

	Benefits	Barriers
All Payer Hospital System	Cost containment: Savings $43 billion to date $2.9 billion in 2008 Increased access to care 1979: $70 million / 5.8% 2005: $800 million /8.0% Prohibits cost shifting Transparency Accountability Minimizes avg markup (18%)	Market setting unique to Maryland Effects hospital policy not physicians Less efficient in larger, local markets Requires political support for success Rates only controlled, not services Markup unchecked (110%-190%)

Source: Buntin,2011 ; Cohen, 2008; Gaynor & Town, 2012 Murray, 2009 ; Pauly & Town, 2012