Maryland's Health Care Price Controls Aren't Solving Problems—They're Creating Them

Peter Suderman

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The 2020 Democratic field, as with much of the Democratic party, is currently fighting about whether to expand Obamacare, allow more people into Medicare, or pursue the more radical option of full-fledged single-payer. But should a Democrat win the White House next year, it's likely that left-leaning wonks will make a push for a somewhat different, lesser-known idea: "all-payer rate setting"—or, as it is more colloquially known, price controls.

The basic idea behind all-payer is that the government sets prices for hospital services in a given region, offering transparency and eliminating the sort of maddening price differentials that frustrate patients, outrage politicians, and make headlines when they are revealed.

In theory, all-payer should hold down health care costs by making it impossible to mysteriously jack up prices for health care services. In practice, however, all-payer ends up captured by the hospitals it is supposed to constrain, adds new layers of confusion to the already complex process of health care pricing, and, although it helps control spending on certain particular metrics, doesn't serve as a meaningful overall check on health care costs.

Those are the main takeaways from Manhattan Institute scholar Chris Pope's new study of rate regulation in Maryland, which has maintained an all-payer system for about four decades. State-based price setting was common in the 1970s and 1980s, but largely disappeared by the 1990s; Maryland is the only state which continued the policy. And it continues, Pope concludes, because the state's hospitals like it, since it effectively guarantees them a large additional income stream from the federal government.

Maryland's all-payer system historically operated under a unique waiver from the federal government that ends up granting the state's hospitals about $2.3 billion a year more than they would get otherwise. The reason this extra pot of money exists is that in Maryland, Medicare rates are much higher than in other states. Typically, the rates Medicare pays hospitals are far lower than the rates paid by private insurers; nationally, private rates are about 67 percent higher than Medicare, a differential that has increased considerably in recent years. In 1997, they were just 13 percent higher.

But that's not the case in Maryland, because the state's all-payer system means that every price is the same, regardless of whether the payer is public or private. This results in somewhat lower private payments—about 13 percent lower than the national average, according to Pope. But it

also means that Medicare rates are much higher than is typical—on the order of 40 percent higher for inpatient services and 60 percent for outpatient.

When all rates are the same, in other words, the rates paid by the federal government go way up, resulting in much higher than usual total payments. Maryland's rate-setting system is designed to extract a windfall from the federal government.

And just because the rates are regulated doesn't mean hospitals don't find other ways to exploit the reimbursement system. For much of the system's life, the state's hospitals posted lower than average growth per admission but had significantly higher than average volume, which allowed them to extract additional money since total reimbursements weren't capped.

That changed somewhat over the last decade with the adoption of so-called "global budgets," a complex system designed to contain total payments to a hospital and prevent volume-based gaming. Early reviews of the state's global budgeting system found that savings didn't always materialize. There are other concerns, too: By capping spending, global budgets have the potential to punish hospitals that attract more patients by offering higher-quality care.

And even in a capped system, there are other ways around the state's rate regulations: As Pope notes, the state is home to more ambulatory surgery centers—which are not bound by all-payer prices—than any other state. There is some reason to suspect that privately insured patients who might pay higher rates are being pushed into those venues.

In addition, the rules themselves become a kind of labyrinth of formulas and adjustment mechanisms. As Pope writes, "decades of reform have seen layers of regulations piled up to deal with the unintended consequences of previous regulation—in turn, generating still additional challenges that must be addressed with still further regulation." Adjustments to the rates are governed by obscure formulas that few really understand.

All of this tracks with previous studies of rate-setting programs. A 1997 *Health Affairs*piece on the history of state-based rate setting found that "the statutes and regulations needed to sustain their rate-setting systems were complex and often incomprehensible." Even in their heyday, it was clear that rate-setting systems had limited usefulness. In 1985, a study in the *Journal of Health Politics, Policy, and Law*, for example, found that states implementing rate setting saw lower per-admission costs but found "no direct evidence that total health care costs" were contained. Although these systems perform well on some targeted metrics, the hoped-for savings have always been something of a mirage.

In part that's because confusion about these systems tends to benefit large incumbents who are better equipped to manage their quirks than lower-cost upstarts. So it is no surprise that Pope describes Maryland's rate-setting process as being "dominated by hospitals," and offers some historical evidence to suggest that the original rules were crafted in part by the state's hospitals themselves.

This is how health care payment schemes almost always are: inscrutable, convoluted, yet somehow designed almost perfectly to funnel as much money as possible to health care providers. As Charles Silver and David Hyman argued in their recent book, *Overcharged: Why Americans Pay Too Much for Health Care*, much of the U.S. health care system only makes sense if you imagine it as a tool for funneling as much money as possible to health care providers.

The limitations of Maryland's program offer a lesson not only for would-be technocrats touting the virtues of price controls on their own but also for those backing single-payer, which, in transferring control of virtually all of the nation's health care financing to the government, would require federal bureaucrats to set rates and budgets. There would be formulas and systems. They would necessarily be complex, because the delivery of health care is inherently complex. And eventually, if not immediately, they would probably be captured by the organizations—especially hospitals—that stand to benefit.