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Commentary

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Kenneth Thorpe's analysis of trends in health care spending in Canada and the United States, which appears in this issue of *JHPPL*, raises several important questions about state health care regulation. Thorpe demonstrates that it is possible to contain costs in the context of a decentralized multipayer system of provider reimbursement, and he cites several U.S. states that were as effective in controlling costs over the past decade as Canadian provinces operating under a single-payer framework. Although Thorpe argues that "expenditure containment and growth ultimately reflect the outcomes of political bargaining among providers and payers," he does not specify the form these bargaining processes have taken or what their impact has been on states' ability to control hospital costs over the past decade. In the end, Thorpe's analysis leaves us with more questions than it answers. In particular, how can we account for significant differences in hospital expenditures between states with similar reimbursement methodologies? Under what circumstances are state governments able to control hospital costs effectively? And what lessons can state experiences with hospital regulation teach us about national health care reform?

The design of regulatory institutions, the policy preferences and economic interests of public and private decision makers, and the ability of public officials to modify providers' behavior all influence the effectiveness of state cost containment programs. The interaction between public

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officials and health providers reflects the larger relationship between state government and the private sector, since the development and implementation of hospital reimbursement policies occur in the context of a state's prevailing cultural and institutional setting. Because both political culture and the autonomy and capacity of political institutions vary from state to state, different regulatory outcomes (e.g., successfully controlling hospital costs) should emerge from different policy environments. In this context, the autonomy, capacity, and legitimacy of state regulation is often as important, if not more so, as the adoption of a particular reimbursement methodology in determining the success or failure of its cost containment initiatives (Hackey 1992).

The Institutional and Ideological Setting of State Hospital Regulation

Several features of a state's policy-making environment influence the development of hospital reimbursement policies. First, the policy-making capacity of political institutions responsible for the development and implementation of rate setting has an immediate impact on a state's ability to control hospital expenditures. A state's level of institutional capacity depends on stable (and adequate) budgetary and political support, the rate of personnel turnover, and the professionalism and expertise of regulatory policymakers. Second, if the governmental actors in the reimbursement process share a sense of mission, it improves a state's ability to control health care costs; if they do not agree over either the means or the ends of regulation, industry groups can play legislators, bureaucrats, and other participants off against each other in the hope of improving their bargaining position. Finally, when public officials can implement policies that run contrary to the preferences of powerful societal interests, state hospital cost containment efforts can be more effective. In states where policymakers lack either the autonomy or the authority to act against the preferences of provider groups, policy outcomes will resemble what happens with interest group liberalism (Lowi 1969) and regulatory "capture" (Stigler 1988; McConnell 1966), in which narrowly defined economic interests dominate the reimbursement process.

The legitimacy of state cost containment efforts has a powerful impact on the behavior of interest groups in the policy process. When state intervention in the hospital sector is seen as entirely legitimate, legal and legislative challenges to the regulatory system will be infrequent and less likely to succeed when they appear. Differences in the influence of public officials and providers also reflect variations in political culture

from state to state, because the role, authority, and autonomy of political institutions are shaped by a state's prevailing political culture and traditions. In general, the more conservative states will be less receptive to government-sponsored solutions such as rate regulation that infringe on the decision-making powers of individuals and firms.

Regulatory Regimes and the Politics of Hospital Reimbursement

The relationship between state governments and the hospital industry falls into three distinct patterns, or regimes, which are biased either in favor of, or against, the development of effective regulatory policies to control hospital costs (Hackey 1992). Each regime represents a fundamentally different balance between the "relative bargaining strengths of purchasers and providers" (see Thorpe in this issue). At one extreme are the imposed regimes, which are defined by an extreme centralization of state regulatory powers, where public officials possess the authority to reshape the hospital reimbursement process to further the state's interests. In contrast, market regimes are notable for the relative underdevelopment of state regulatory authority and a hesitance on the part of policymakers to use the few powers granted to them. In states where regulation and traditional patterns of provider dominance remain in conflict, hospital reimbursement policy is governed by a negotiated regime.

Imposed Regimes

Under an imposed regulatory regime, the belief that the state has a legitimate role in regulating hospital reimbursement fosters an environment in which cost control initiatives can be successfully developed and implemented. Political support from the executive branch and the legislature also gives state officials more leverage with industry groups. Imposed regimes are highly institutionalized: low turnover among bureaucratic and legislative personnel responsible for health care reimbursement issues contributes to the development of specialized knowledge and a shared commitment to controlling health care costs.[1] For a state's hospital regulatory policies to be classified as an imposed regime, however, public

1. See, for example, Wilson's (1989: 95–110) discussion of the impact of a cohesive organizational mission on the performance of the U.S. Forest Service, the U.S. Army Corps of Engineers, and the Social Security Administration and Perrow's (1990) account of the effect of goal conflict and goal displacement on New York's response to the emerging AIDS epidemic during the 1980s.

officials must possess a well-defined set of policy preferences that they are able to implement consistently as public policy.

Market Regimes

The relationship between providers, payers, and the state is fundamentally different under a market regime, where public officials possess little or no formal authority to regulate the hospital industry. Under these circumstances, regulatory agencies are unlikely to be catalysts of change, for the prevailing political culture favors private solutions to public problems, in the spirit of Grant McConnell's (1966) "orthodox tradition" as both a more efficient and less threatening solution than state intervention. Consensus on ideological and programmatic goals among participants and relevant publics in the health policy network is typically high, for the state imposes few requirements on either providers or payers; responsibility for negotiating reimbursement rates rests squarely with the private sector. A stunted bureaucracy also limits the state's ability to develop and implement innovative cost control policies, because both "managed competition" and rate-setting strategies typically require that government officials assume an activist role (Morone 1992).

Negotiated Regimes

The most common policy-making arrangements, however, fall somewhere between these two extremes, where the ability of public officials to change providers' behavior is limited by both institutional and ideological constraints. Under a negotiated regime, state efforts to control costs are often hampered by high personnel turnover, conflict over program goals, inadequate funding for state regulatory agencies, and ideological resistance to regulatory initiatives. Policy development and implementation has a strong corporatist flavor, as state officials must turn to industry groups for both political support and administrative assistance. Negotiated regimes thus reaffirm Huntington's (1968: 5) contention that the "primary problem of politics is the lag in the development of political institutions behind social and economic change."

The framework outlined above can shed some light on the questions posed by Thorpe's analysis, because the hospital reimbursement decisions that he discusses in California, Maryland, Massachusetts, New Jersey, and New York occurred in the context of either imposed or negotiated regimes. In each state, government officials adopted an activist role in

the hospital reimbursement process, either by creating an all-payer rate-setting system or by designing an elaborate system of competitive bidding for health services (e.g., Medi-Cal). In the pages that follow, I explore the impact of differences in political culture and institutional arrangements on cost containment in two of those states, Massachusetts and New York, over the past decade.

New York

New York's experience with hospital rate setting can best be understood as an imposed regulatory regime. In no state was the "public utility" model of rate regulation more conspicuous than in the Empire State; by the early 1980s, the hospital industry had lost much of its capacity for autonomous decision making. While the state's initial forays into hospital rate regulation in the 1970s only set rates for Blue Cross and Medicaid, the scope of state regulatory authority gradually expanded to include all payers with the creation of the New York Prospective Hospital Reimbursement Methodology (NYPHRM) in 1982. When New York declined to renew its Medicare waiver after the expiration of NYPHRM I in 1985, subsequent versions of the state's prospective payment system operated as a "Medicare wraparound," setting rates for all non-Medicare payers.

Although the state's fiscal crisis during the 1970s provided the impetus for officials in the Department of Health (DOH) to engage in increasingly aggressive efforts to control the growth of hospital costs, the enormous expense of Medicaid insured that hospital cost control remained a policy priority. New York's fiscal obligation to Medicaid is staggering; throughout the 1980s, the Empire State led the nation in total Medicaid program expenses, per capita Medicaid spending, and the number of Medicaid recipients as a percentage of the state's population. The fiscal burden of Medicaid helped to forge a broad consensus among public and private payers over the importance of bringing hospital costs under control; with strong support from both the governor's office and the legislature over the past decade, officials in the Department of Health presided over a regulatory apparatus that presented hospitals with one of the most competitive, if not openly hostile, operating environments in the nation.

New York has a long tradition of regulatory activism in the health sector, dating back to the Metcalf-McClosky Act of 1964, which introduced one of the nation's most stringent certificate-of-need programs to curtail hospitals' capital expansion. Although providers have challenged both the Department of Health's regulatory decisions and its rate-setting powers,

the department's regulatory authority has generally been upheld in court. The Hospital Association of New York State has vociferously opposed the state's reimbursement policies and has often found a receptive ear in the legislature, but endorsements from Blue Cross, business groups, and the governor's office generally supported the DOH's aggressive pursuit of cost control over the opposition of the hospital industry.[2] During the 1980s, the relationship between the state's hospital industry and the department reflect a level of animosity seldom seen in American politics. While hospitals fumed over the Department of Health's "micromanagement" of provider reimbursement and the lack of turnover among senior managers in the DOH, Commissioner Axelrod compared the state's hospitals to "seventeenth-century Germanic guilds" in speeches to the state's business community. Under these circumstances, as one hospital executive quipped, "it's tough to get people to be statesmanlike." By the end of the decade, the department had forced hospitals to shoulder the brunt of the cost for implementing new minimum operating standards, thwarted repeated efforts by providers to move the base year for calculating reimbursement rates, and successfully managed the transition from a per diem reimbursement methodology to a new case-based payment system using diagnosis-related groups (DRGs). Even after the unexpected retirement of Commissioner David Axelrod in 1991, the Department of Health remained firmly committed to controlling hospital costs.

The ability of policymakers over the past decade to resist industry pressures and persist in their efforts to keep hospital costs under control reflected the capacity of New York's policy-making institutions in the health sector. In particular, the institutionalization of expertise within both the DOH and the legislature's principal incubator for health policy development, the Council on Health Care Financing, provided state officials with a crucial advantage in reimbursement negotiations. While providers criticized low turnover in key policy positions within the Department of Health, the presence of a highly professionalized and experienced staff enabled the state to develop and implement innovative regulatory policies

2. In 1990, however, neither the governor nor the legislature was predisposed to wage a protracted battle over hospital costs because of the upcoming statewide election. Instead, the reenactment of the state's case payment system became an opportunity to appease powerful constituencies. The legislature rejected the DOH's proposal to pay providers on the basis of a "group price," where institutions' level of reimbursement is based on the average costs for a group of peer institutions rather than their own historical experience and pumped more than $300 million in additional revenues into the hospital reimbursement system over a three-year period. This decision, however, was unusual, and stands in marked contrast to the policies adopted by the legislature and implemented by the Department of Health in previous years.

Table 1 Personnel Stability under an Imposed Regulatory Regime, New York State Department of Health, Office of Health Systems Management, 1991

Name	Position	Appointed	Previous Departmental Experience
Raymond Sweeney	Director	1984	Executive deputy director (1981–83); associate director, DHCF (1979–81)
Brian Hendricks	Executive deputy director	1984	Governor's Select Commission (1983–84); deputy director, Health Planning Commission (1979–83)
Steve Anderman	Deputy director, DHCF	1982	Assistant director, DHCF (1979–82)
Mark Van Guysling	Assistant director, DHCF	1982	Assistant director, Bureau of Hospital Reimbursement, DHCF (1978–82)
William Gormley	Deputy director, DHFP	1989	Assistant director, DHCF (1979–88)
Nicholas Mangiordo	Deputy director, ALTCS	1989	Deputy director, DHFP (1979–89)
Michael Parker	Associate director, CON	1979	Director, Bureau of Facility and Service Review, DHFP (1976–78)

Note. DHCF: Division of Health Care Financing; DHFP: Division of Health Facility Planning; ALTCS: Alternative Long Term Care Strategies; CON: Certificate of Need Review Group, DHFP.

over the past decade (see Table 1). During the 1980s, New York led the nation in developing new DRG classifications for neonatal conditions and AIDS, significantly improved its DRG grouper in 1990, and began planning for improvements to be incorporated into the latest version of the state's case-based payment system (NYPHRM IV). In short, the technical sophistication and policy expertise of New York's health bureaucracy enabled it to respond to a changing environment by setting the state's policy agenda. In other states, however, state rate-setting programs were less dynamic and were unable to respond to new demands and pressures.

Massachusetts

Massachusetts's experience with rate regulation illustrates the perils of regulatory policy-making in an unstable political environment. Less than a decade after the introduction of all-payer rate setting, hospital rate regulation self-destructed and was effectively discredited as a cost control strategy in the eyes of payers, providers, and former legislative supporters. In 1991, the Weld administration's proposal to deregulate the reimbursement system passed comfortably in both the House and the Senate, effectively ending the state's foray into hospital regulation. Few mourned its passage. The demise of rate setting in Massachusetts presents a puzzle: Why did Massachusetts and New York have such different experiences with all-payer rate setting, despite the similarities between their reimbursement methodologies? Furthermore, what led Massachusetts to turn its back on regulation scarcely a decade after it came to national prominence?

Although the state's authority to regulate hospital reimbursement expanded considerably over time, support for regulation in Massachusetts depended on a fragile coalition of payers, providers, and business groups brought together to support the state's first all-payer system (Chapter 372) in 1982 (see Bergthold 1988). After the passage of Chapter 372, the Massachusetts Rate Setting Commission (MRSC) took a less active role in policy development as the locus of decision-making authority shifted to the legislature. In sharp contrast to New York, the institution with the most experience regulating health providers was relegated to a marginal role, since subsequent reenactments of the all-payer system in 1985 (Chapter 574) and 1988 (Chapter 23) actually specified the terms of the contracts between providers and payers. In the legislative arena, however, hospital reimbursement soon fell victim to the vagaries of the political process as payers, providers, and business groups pursued their own narrow economic interests.

The origins of all-payer rate setting in Massachusetts also constrained the state's ability to implement policies opposed by powerful societal groups. The state was a reluctant participant in the process which produced Chapter 372; legislators simply ratified an agreement hammered out under the prodding of the state business community, led by the Massachusetts Business Roundtable (MBRT) (Bergthold 1988). Chapter 372 reflected the concerns of the state's business community that hospital costs were spiraling out of control. The all-payer system provided hospitals with a strong incentive to cut operating costs, control admissions,

and shift patient care to less expensive, outpatient settings when it linked reimbursement to patient volume and imposed new "productivity" incentives on hospitals. Business supported both Chapter 372 and its successor, Chapter 574, as a welcome step toward cost reduction. When the all-payer system came up for renewal in 1988, however, the political environment had changed. Hospitals demanded a relaxation of the strict productivity requirements and sought additional funding to offset rising labor costs for nurses and other allied health personnel in exchange for their support of the Dukakis administration's health care reform agenda. In the end, the passage of the universal health care bill (Chapter 23) was a watershed for rate regulation in Massachusetts: its generous treatment of providers was a bane to business groups and a boon to providers. The coalition that had framed Chapter 372 collapsed after the passage of Chapter 23. After losing badly in the legislative debates in 1988, business effectively withdrew from health policy debates to pursue other issues, such as worker's compensation and tax reform.

Blue Cross, for its part, felt increasingly constrained because the regulatory framework embodied in Chapter 23 prevented the company from flexing its muscle in a more competitive bidding process. By 1988, the state's cumbersome proto-DRG system appeared anachronistic and inflexible to providers and payers alike. High personnel turnover and budget cutbacks, however, prevented the MRSC from either improving the system or developing a worthy successor; with few resources, the MRSC was overwhelmed with the day-to-day administration of the payment system. Staff cutbacks, a statewide hiring freeze, and the attractiveness of opportunities in the private sector drained the MRSC of several of its most talented managers; leadership of the MRSC's Bureau of Hospitals changed hands four times between 1985 and 1990, while other key positions remained unfilled. The arrival of the Weld administration in 1990 sealed the fate of rate setting, for the governor and his staff sought to eliminate, not enhance, the MRSC's regulatory authority as part of a general campaign to "downsize" state government.

Massachusetts's experience in controlling costs during the 1980s reflects the turmoil and instability of a changing political environment. The state was more effective in controlling the growth of hospital expenditures in the early years of the all-payer system, when the various parties shared a consensus on both goals and means. As this consensus began to fray in the mid-1980s, the legislature made significant concessions to the hospital industry in order to win reauthorization of the reimbursement system, undermining the system's ability to control costs. From 1982 to

Table 2 Hospital Expenditures under Selected State Rate-setting Programs, 1982–1989

State	1982 (dollars)	1986 (dollars)	1987 (dollars)	1989 (dollars)	Percentage Change 1982–86	Percentage Change 1987–89	Average Change 1982–86	Average Change 1987–89
Maryland	1,769,362	2,266,202	2,455,947	3,022,679	28.08	23.08	7.02	11.54
Massachusetts	3,582,627	4,598,913	4,944,140	6,160,608	28.37	24.60	7.09	12.30
New Jersey	2,926,344	4,137,488	4,458,193	5,813,699	41.39	30.40	10.35	15.20
New York	9,436,920	13,179,965	14,182,866	17,362,865	39.66	22.42	9.92	11.21
Rhode Island	431,032	593,767	651,505	788,259	37.75	20.99	9.44	10.50

Notes. Expenditures are for short-term general and other special hospitals.
Data obtained from the American Hospital Association's annual survey of U.S. hospitals.

1986, hospital expenditures in Massachusetts increased, on average, at slightly more than a 7 percent annual rate, reflecting the stringency of the new cost control mechanisms introduced by Chapter 372. After 1986, however, the Bay State was much less successful in controlling costs, as annual increases in hospital costs nearly doubled, averaging more than 12 percent from 1987 to 1989. Although Medicaid placed a heavy burden on both Massachusetts and New York, the stringency of NYPHRM's all-payer reimbursement methodology successfully limited the growth in program outlays. In New York, Medicaid expenses increased 147 percent from 1975 to 1988, compared to a whopping 332 percent increase during the same period in Massachusetts (HCFA 1988). While hospital expenditures increased in all of the states described in Table 2, the rate of growth in Massachusetts and New Jersey far exceeded that in New York, where strong political support and an experienced policy-making team continued to campaign for cost control at the end of the decade.

Conclusion

In the end, state efforts to control hospital costs have much to teach policymakers about national health care reform. More than three decades after rising health care costs first became an issue of public concern, policymakers and the public continue to search for a "quick fix" to the nation's health care dilemma. Too often, our search for solutions begins, and ends, with various methods for reorganizing the health care system (such as HMOs), reforming provider payment (DRGs), or rationalizing the production of health services (HSAs, PSROs, and PROs). Thorpe's analysis, however, suggests that no single reimbursement methodology, in and of itself, holds the key to controlling health care costs. Instead, the problem is a political one, linked to the peculiar institutional and ideological context of American health policy.

Successful cost control, therefore, depends not on whether providers are reimbursed by a single payer or multiple payers, paid prospectively or retrospectively, or whether reimbursement is computed on a per diem, per case, or global budget basis. As Foster (1982) notes, the rate of reimbursement can be set at a high or low level under any payment methodology. Cost control is inextricably linked to the capacity and autonomy of regulatory institutions, for without adequate authority and expertise, government will be hard pressed to design and implement an effective health care financing system. The experiences of Massachusetts and New York over the past decade also lend credence to Sapolsky et al.'s (1987: 135) observation that "it is less difficult to bring together a talented group

for designing a new program than it is to hold one together for the arduous task of program implementation and refinement." Decentralizing cost control responsibilities is desirable, because it would permit continued experimentation with various methods of organizing and financing health care services, despite the states' inability to significantly improve access to health services (see Stone 1992). Any proposal for national health care reform which leaves policy implementation in the hands of the states, however, is likely to require institution building, for not all states possess the institutional leverage to negotiate effectively with providers and payers. If a decentralized strategy is to succeed, the federal government must be willing to bolster the states' regulatory capabilities; without technical expertise and a clear mandate to control costs, neither state nor federal efforts are likely to reduce health care expenditures significantly in the years to come.

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