HEALTH

In Praise of Price-Fixing

Americans face a constant (and often Sisyphean) struggle against health care inflation. Maryland found an answer. By Margot Sanger-Katz

Early this month, the International Federation of Health Plans issued a graphic reminder of why health care costs are so much higher in the United States than in the rest of the world: the prices. Americans pay *much* more for individual services such as MRIs and hip replacements. A CT scan of the head costs $141 in France, $272 in Germany, and an average of $510 for Americans with private insurance. The U.S. system has very little price regulation; the 2010 health care law—which focused its cost-control measures on prevention, coordinated care, and unnecessary treatments—avoided telling hospitals what they could charge private insurers.

But just outside Washington, Maryland is running a 40-year experiment in price control—with impressive results. The state's Health Services Cost Review Commission, whose members are appointed to four-year terms by the governor, has created a system like those in France and Germany, where regulation helps determine hospital prices. The results speak for themselves: Maryland has kept price inflation below the national average, maintained quality, and ensured the financial stability of hospitals, including the types of community facilities in poorer neighborhoods that have struggled and closed elsewhere.

Maryland's system is what health care economists call all-payer rate-setting. The cost-containment board looks at services and hospital needs and then selects a uniform menu of prices for all payers. In most states, prices for the same procedure vary. Some payers, usually the public ones such as Medicaid, get a steep discount, while others pay more to make up the difference. (The country's most expensive CT scan of the head is $1,545, according to the international health-plan study.) In Maryland, Medicare, Medicaid, private insurers, and patients who pay cash all get the same bill for a CT scan. It means that bigger, more powerful hospitals can't demand higher prices from insurers. It also means that hospitals that treat Medicaid patients don't get bankrupted by skimpy reimbursement rates.

In 1976, a few years after rate-setting went into effect, the average price for a hospital admission in Maryland was 25 percent above the national average. By 2009, it was 3 percent below. Robert Murray, the commission's former executive director, estimates that the all-payer policy has saved the state $45 billion over that time. Prices there are not the cheapest in the country, but its hospitals have experienced the lowest growth per patient at the hospital level of any state during that period.

The system also pushes hospitals to hit quality targets and improve the standard of care. In the two years after the commission introduced quality incentives to reduce certain preventable complications, the rate fell by 20 percent. And although Medicaid patients tend to have difficulty accessing care in most of the country because hospitals are disappearing from poor neighborhoods, that's less true in Maryland. Compare Baltimore to Detroit, two similarly sized cities populated by low-income African-Americans. Detroit has lost 87 percent of its hospitals since 1970 as more providers have migrated to richer suburbs, leaving only the big university facilities. In Baltimore, only 31 percent of hospitals have closed; several remain in poor, black neighborhoods. Rural Maryland counties are underserved, but the numbers have not eroded much in the decades since rate-setting began. "In other states, you have to worry more about stratification of the market, and I think you do have to worry more about essentially two-tiered systems that would disadvantage Medicaid beneficiaries," said Charles Milligan, the state's Medicaid director, who ran the Medicaid program in New Mexico. "That is not the case in Maryland."

Hospital Erosion

Hundreds of U.S. urban hospitals closed over the last 40 years as cities shrank, neighborhoods changed, and poverty rates soared. Baltimore fared better than several comparable cities, losing hospitals in proportion to its population decline.

Change, 1970-2010

City	Hospitals	Population	Poverty rate
Detroit	-89%	-53%	+29 pts
St. Louis	-68	-49	+17
Cleveland	-63	-47	+25
Newark	-57	-28	+21
Baltimore	*-31*	*-32*	*+14*

Sources: Hospital data copyright, Dr. Alan Sager, Boston University School of Public Health; Census Bureau

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An all-payer system can also be good for insurers, health economists argue (although Maryland's insurance market is not abnormally competitive). In theory, if insurers face a level playing field for prices, they might focus on other ways to keep premiums down—such as internal efficiency or quality of care. Small, more-innovative players might also have an easier time joining the market. "If you actually control rates reasonably, then the competition is on the important stuff, not who has more market power," said Dr. Robert Berenson, a physician and a senior fellow at the Urban Institute. "Rate-setting actually promotes market competition."

Not that Maryland is perfect. As in any business, health care providers game the regulations to maximize profits. Doctor's visits aren't included in the all-payer system, so those prices have risen along with the rest of the country. In 2000, the board eliminated a payment model that discouraged hospitals from treating more patients to make up for lower compensation. Since then, hospitals have started admitting more patients, potentially imperiling the effects of price moderation. The board's response could determine whether Maryland continues to constrain overall cost growth or becomes just a regulatory anomaly.

But if hospitals are barred from frivolous admissions, all-payer rate-setting clearly can work in the United States. Vermont is considering a similar system. Politically, however, it requires a state committed to both setting tough regulations and policing cronyism. Maryland, after all, is a consistently blue state with little political opposition to price-setting. "There is something critical in that 40 years of collaboration that makes it work," said Carmela Coyle, president of the Maryland Hospital Association, which supports the system. "I don't know if you could just lift it up and pop it into somewhere else." ■

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