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The political economy of hospital rate regulation in Maine

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Ten years ago, Maine established a health care finance board to regulate hospital rates. But the concerns that prompted the regulatory system, access and cost, have not abated. In this article, former Maine Health Care Finance Commission chair David Wihry, and former Commission staffers Julie Fralich and Ellen Jane Schneiter examine the economic and political influences that have affected the state's efforts to regulate hospital costs.

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Introduction

In 1983, Maine joined the ranks of a handful of states that chose to regulate hospital rates. On the tenth anniversary of the Maine Health Care Finance Commission (the "Commission"), we would like to examine the political and economic forces that have impinged upon the regulatory process. The concerns about accessibility to health services for low income people and about escalating health care costs that prompted Maine's rate control program have not gone away. Indeed, they have moved health care reform to the forefront of the national policy agenda and have stimulated a move for broader cost containment and access policies at the state level. The Clinton Administration's health care proposals may well place substantial responsibility on the states to implement and perhaps even to design programs to expand access and to restrain costs. A review of Maine's experience with the economic regulation of hospitals may provide clues about how to enhance the effectiveness of government intervention in this important and difficult arena. Maine's experience may be particularly relevant to understanding the opportunities and the constraints presented by the "global budgeting" and other proposals now under consideration.

The present discussion will address almost exclusively what could be called the "first phase" of the Commission's existence. Legislation passed in 1989 in response to recommendations from a "Blue Ribbon Commission" mandated some major changes that have been implemented only recently. An assessment of this second phase would be premature.

We begin with an overview of the essential elements of the regulatory system. We then describe the industry reaction to regulation and the impact of that reaction on the Commission. We go on to reflect on the balance of political forces that have shaped the Commission's experience and end by reflecting on the role of hospital rate regulation and on some specific lessons that might bear on regulatory effectiveness.

Maine's system of hospital regulation

Background

Maine's regulatory system replaced a voluntary budget review program implemented in 1978. The voluntary program had the support of the hospital industry, which viewed the initiative as an

opportunity to demonstrate that hospitals were capable of effective self-regulation, negating any need for public control. The program required all hospitals to participate in a budget review process. However, no hospital was required to live within the approved budget or to abide by the comments of the Voluntary Budget Review Organization.

The Maine Health Facilities Cost Review Board, an agency that had been set up to monitor the program, found the voluntary system ineffective and urged, along with the leadership of the Department of Human Services, that the state establish a mandatory rate review program. The administration worked with the Joint Committee on Human Resources to guide through the legislature the statute creating the Maine Health Care Finance Commission and the regulatory program that it administers. The expressed intent of the legislation was to create a regulatory system that would appropriately limit the rate of increase in hospital costs, while protecting the quality and accessibility of hospital services throughout the state by assuring the financial viability of an efficient and effective hospital system. Objectives expressed in the statute also included encouraging hospitals to operate efficiently, promoting equity among payers, and allowing insurers predictability in payment amounts and a voice in the determination of reasonable hospital costs. The statute contained no explicit performance standards against which the effectiveness of the regulatory program would be judged. The regulatory system is administered by an executive director and his/her staff, who report to five part-time commissioners. The Commissioners are appointed by the governor, with the consent of the legislature, for staggered four-year terms. The Commission is an independent executive agency funded by an annual charge added to each hospital's financial requirements (and, for a number of years, by an additional state appropriation). The current members of the Commission are: Rosalyn Bernstein, chair; Elinor W. Goldblatt, vice chair; Harvey Picker; Richard B. Dalbeck; and Robert A. Strong. The executive director is Robert K. Clarke.

A formula-driven system

The regulatory system attempts to restrain the growth in hospitals' expenditures by controlling the growth in their revenues. Prior to each hospital's fiscal year, the Commission issues an order assigning the hospital an authorized level of total revenue. The revenue limit is designed to generate enough net revenue to cover what the system defines as the hospital's "financial requirements," the amount it needs to operate during that year. The concept of financial requirements plays a key role, since the level of each hospital's expenditures is determined not by the hospital's choice but by a system of public choice. This system implements statutory language through agency rules and decisions that specify what each hospital's financial requirements should be.

The system's enabling legislation made the determination of financial requirements essentially formula-driven. The starting point for calculating a revenue limit was the hospital's base-year financial requirements, which were defined by statute as the expenses the hospital budgeted in its last fiscal year under the voluntary budget review system. Non-capital financial requirements were then adjusted annually to reflect changes in factors judged, in effect, to be beyond the hospital's control. These adjustments, all defined by rules that interpreted the statute, accounted for changes in volume of services, case mix, and input prices. The capital component of financial requirements was defined to include actual principal and interest payments, a downpayment on

replacement for facilities and fixed equipment, and price level depreciation for movable equipment.

The discretion to make further adjustments in financial requirements was severely constrained by the statute. The Commission could review cases on an individual basis and could adjust financial requirements for the impact of unforeseen and uncontrollable events. The Commission was also given the authority (after the first two years) to establish a state-wide cap on the amount of new financial requirements that could be approved through the Certificate of Need (CON) program administered by the Department of Human Services. Financial requirements would be adjusted for CON-approved expenses as long as their costs did not exceed the state-wide cap (which was eventually called the Hospital Development Account).

Once the hospital's financial requirements were determined, a limit on the total amount of charges the hospital would be allowed to levy was computed. This gross revenue limit included mark-ups to financial requirements to cover uncompensated care, payor differentials (the discounts permitted insurers in limited circumstances), and the shortfalls in payments by Medicare and Medicaid.

The net effect of these adjustments was to hold the hospital responsible for any increases in expenses that exceeded financial requirements. The hospital was free to implement a rate structure that would, over the course of the year, generate the approved revenue and would assure that the hospital's financial requirements were met. If the hospital spent less than its financial requirements, it was still allowed to generate its revenue limit and keep the savings. If a hospital collected more than its revenue limit, it was penalized for overcharging through an adjustment to a subsequent year's revenue limit.

To ensure consistency, equity, and enforceability, the rules became both lengthy and detailed. The rules described with painstaking precision the formulas that would be used to calculate hospital input price inflation, changes in the volume of services, changes in case mix (among many other considerations), and the hospital's revenue limit. The complexity of the rules reflected the difficult choices required to translate relatively clear-cut concepts into operational definitions. Some of the issues the Commission had to address included: How are changes in volume to be estimated prospectively? Should volume projections be revised at year end to reflect actual changes in volume? What degree of accuracy can be achieved with an input price index? Should increases in the cost of such items as malpractice insurance be treated as a component of inflation or as an unforeseen event? How should the costs of new technologies and drugs be treated? Should these costs be incorporated into financial requirements through one of the formula adjustments or as unforeseen events? These issues and many others were the focus of the Commission's early policy decisions as it shaped its rules and responded to the many appeals that were filed by hospitals.

The principal alternative to the formula approach would have been budget review. Budget review would entail a periodic, or at the very least an initial, examination of a hospital's historic or proposed expenditures for "reasonableness." The designers of Maine's program rejected the budget review concept on several grounds, primarily because of the difficulty of defining either in principle or in practice what constitutes "reasonable" financial requirements. Hospitals would

always have better information about a given budget item than would the regulatory agency; virtually any expenditure could be justified in isolation as being reasonable; and the state may well have been unwilling to commit enough resources to support a truly effective review process. Further, the level of micro-management implied by budget review probably would have been unacceptable in Maine's political climate. Moreover, the new system was to replace a voluntary budget review program that supporters of mandatory rate regulation saw as a dismal failure. These arguments against budget review were compelling at the time and remain so today.

New constraints

The response of the hospital industry to regulation was generally negative, and understandably so. Prior to the early 1980s, the hospital industry in Maine had been constrained neither by market forces nor by governmental authority. The voluntary budget review system provided some appearance of public accountability, but the hospitals were not bound by it. The introduction of Medicare's prospective payment system (PPS) in late 1982 was the first significant cost containment initiative by any major payor to be encountered. PPS hit most of Maine's rural hospitals hard and created shortfalls in Medicare revenues that grew markedly over the years. Still, these hospitals were free to recover lost revenues by cost shifting between revenue centers and payers in any manner that they saw fit.

The new payment system radically altered the hospitals' financial environment. First, the regulatory system makes no provision for profit. A hospital's allowed net revenues are set equal only to its financial requirements as defined by the regulatory system. (For the state's two proprietary institutions, Jackson Brook Institute and the New England Rehabilitation Hospital of Portland, a provision is made for a fair return on equity.) The legal and philosophical justifications for not including profits are sound. Non-profit hospitals can, and often do, generate profits, in the accounting sense of revenues in excess of expenses, but no human person has the right to claim a share of these profits; they must be retained by the non-profit corporation. Further, part of the impetus for creating the regulatory program was a desire to control the level of profits of nominally non-profit institutions. But profit is seen by hospitals as an important tool for financing growth. In the new environment, profit could be generated only by cutting expenses below approved net revenue. This task would require much more active management and much more vigorous constraints on physician behavior than had been required of administrators ever before.

Second, hospitals argued from the beginning that, because of its formula-based nature, the payment system was insensitive to their diversity and complexity. The uniqueness of each institution was a common refrain from hospital representatives who appeared before the Commission and before legislative hearings. More specifically, some hospitals had budgeted generously in their base year while others had not. Some hospitals appeared simply to have been operating more efficiently in their base years than others. The low-cost, under-budgeted institutions had a complaint that seemed to them and to sympathetic legislators to be persuasive.

Fundamentally, the new system virtually ensured that hospital revenues would no longer be adequate to accommodate all of the additional expenses that hospitals might wish to incur. The payment system ran squarely up against the common hospital desire for growth in the size, in the

scope of services, and in the technological sophistication of the institution. The radical change in the regulatory environment presented hospitals with the choice between trying to live within the new constraints or trying to change them. Increasing hospital operating deficits and a broad-based assault on the Commission's statute and rules indicated that many hospitals chose the latter path.

The industry reaction

The industry response to regulation was launched on all fronts: public relations, legal, and political. We will focus on various dimensions of the legal and political response.

The legal challenges to the regulatory structure initially took the form of notices of contest filed with the Commission by hospitals that were unhappy with the revenue limits proposed by the executive director. The notice of contest procedure is required by the statute, is defined in the Commission's rules, and is shaped by the requirements of the Administrative Procedures Act (APA). The procedure afforded any aggrieved party an opportunity to make a case to the Commission staff (in the presence of other affected parties) and ultimately directly to the Commission. It was clear that some hospital officials had hoped simply to engage in informal discussions with the staff and the commissioners. To protect the interests of affected parties uniformly, the Commission insisted on adhering to the formal procedures written into its rules. Numerous unresolved contest notices led to hearings, Commission deliberations, and court cases. The hospitals' unwillingness to accept the application of a set of rules that, in the minds of the commissioners and their staff, straightforwardly implemented the statute, was an unpleasant surprise to the system's designers. The well-defined legal requirements of the adjudicatory process were, in turn, an unpleasant surprise to many hospitals, especially the smaller ones. The system came to be viewed as overly legalistic, with some hospital officials complaining that they could not even begin to approach the Commission without first retaining the services of an expert attorney.

Notices of contest often raised issues of policy, but the Commission's ability to address such issues in the context of adjudicatory proceedings was severely limited. The Commission's policy decisions were reflected in its rules, and the rules were constructed -- to ensure evenhandedness - - to discourage exceptions. The Commission adhered firmly to the principle that its rules could not be changed through adjudicatory proceedings but only, in accordance with the APA, through public hearings at which all potentially affected parties could participate. Since the Commission was bound by its rules, virtually all of the Commission's early adjudicatory decisions favored the executive director rather than the hospital. This contributed to the perception that the Commission was inflexible, captive to its staff, and biased against the industry.

Some hospitals, unhappy with the Commission's decisions favoring the executive director, appealed to the courts. Appeals of Commission decisions went to the state courts which in most cases found for the Commission, but which in some instances overturned the Commission's rules as contrary to the statute. A loosely aligned group of hospitals challenged the constitutionality of the entire regulatory structure in federal court. Their case was premised on the argument that the Commission was unlawfully using Medicare savings generated by hospitals under PPS to offset financial requirements and to reduce charges to other payers. Eventually, the federal courts failed

to find in favor of the hospitals and decided that this was a state, not a federal, issue. Still, the federal case, when combined with the abundance of other adjudicatory matters facing the Commission and its staff, exacted a toll.

On a second front, attempts emerged to amend Commission rules through lobbying the staff and Commissioners and through the formal APA hearing process. The industry pressed the position that the formula adjustments to financial requirements were inadequate. One of the most significant controversies related to the adjustment to financial requirements for changes in patient volume and severity of illness. This adjustment applied a marginal cost factor to account for increases or decreases from year to year in the number of patients discharged. Such discharges were adjusted to reflect the relative severity of a particular facility's patient population. This adjustment was made prospectively based on the actual case-mix-adjusted volume experienced two years earlier. Initially, however, no year-end reconciliation to actual patient volume was incorporated into the volume rule. The hospitals complained about the lack of sensitivity of the case mix measure used by the Commission (the same index used by Medicare) to their particular patient populations, about the failure to recognize longer than average lengths of stay, and about the inadequacy of the marginal cost factors. They also complained vigorously about the two-year lag built into the rules. The Commission eventually agreed to implement a year-end reconciliation to actual volume. This adjustment detracted somewhat from the prospectivity of the system. The concession seemed expedient in light of the possibility of protracted law-suits over the issue and the potential political costs of not accommodating hospital concerns.

There were other pressures exerted against the rules. Marked fluctuations in liability and malpractice insurance rates generated a backlash against the Commission's inflation adjustment methodology. Although malpractice coverage comprised, on average, less than one half of one percent of hospital financial requirements, the issue of increasing insurance costs was raised often in notices of contest. Eventually, the Commission agreed to change its rules to allow hospitals to recoup actual changes in liability and malpractice insurance costs. Similarly, the "nursing shortage," which the industry argued existed during the mid-1980s, precipitated demand for additional financial requirements to cover all increases in the wages of hospital professional staff that exceeded the annual inflation adjustment. Recognizing that the legislature would accommodate the hospitals' desires, the Commission helped draft the statutory language that would make such adjustments possible. The Commission did convince the legislature to incorporate a set of conditions that hospitals would have to meet to qualify for this adjustment. To qualify, the hospital must demonstrate an "economic hardship," which was defined as an excess of non-capital operating expenses over non-capital financial requirements. While this provision ensured that each hospital used its allotted revenues before financial requirements would be increased, some observers believed that the provision added an incentive to expend all revenues available.

As noted above, the system included provisions for *ad hoc* adjustments in financial requirements, at the Commission's discretion, to reflect the cost of "unforeseen and uncontrollable events." The hospitals saw this provision as a loophole through which they attempted to pass various items, such as the malpractice insurance premium increases discussed above and changes in the cost of contractual arrangements with physicians. The Commission also saw the provision as a loophole

and, much to the frustration of the hospitals, kept the size of the loophole to a minimum. The Commission conceded to a limited degree by accommodating such items as the additional expense of federally-mandated HIV and hepatitis precautions and the additional expense of new treatments (*e.g.*, the use of tPA in the treatment of heart attacks) or technological innovations that hospitals could argue convincingly had become standards of practice. However, the Commission earned a reputation for being reluctant to make such adjustments, and hospital administrators continued to argue that the system did not accommodate what one hospital official called "subtle changes" in hospital expenses. The Commission's position was that such subtle changes could have been and should have been financed by savings elsewhere in the hospital's budget.

Hospitals also were displeased with the Commission's performance in another area: the sizing of the Hospital Development Account (originally the Certificate of Need Development Account). The Hospital Development Account places an annual cap on total additions to financial requirements, across all hospitals, that can be approved through the CON process. The initial "credits" to the account were established by statute at one percent of expenses approved under the voluntary budget review program for the first payment year, and one percent of first payment year financial requirements for the second payment year. Thereafter, the Commission was responsible for establishing the amount of the credit. Year after year, the size of the credit was a focus of controversy. The credit for the third year was predicated on an estimate of hospital CON projects that were expected to be submitted for review during the year. A credit of \$6.44 million for the third year was approved, an increase of five percent relative to the previous year, even though the increase exceeded projected growth in personal income in Maine, one of the Commission's standards of affordability. In the fourth year, the Commission approved a credit to the development account that was formulated by trending the third year's credit forward for projected inflation. The resulting figure fell far short of the \$17 million cost of the 38 pending projects that had been submitted by hospitals for CON approval. The Commission argued that, even without a credit to the Development Account, hospital charges to private payers would increase by 14 percent during the fourth year, due to the combined effect of the routine formula adjustments and the increasing revenue shortfalls created by Medicare and Medicaid. Since Maine citizens' income was expected to increase by less than eight percent, the staff and commissioners contended that even the first dollar expended on any CON project would, by definition, be unaffordable. Although the Commission expressed a willingness to reconsider the credit to the account during the year upon the request of the Commissioner of the Department of Human Services, who was responsible for CON approvals, the Maine Hospital Association made a direct appeal to the legislature. The legislature subsequently enacted and the governor signed a bill that added \$7.8 million to the Development Account.

The hospitals regularly sought legislative approval for changes in the statute, generally without Commission support. Some proposals were approved, others were rejected. In one instance, the Commission joined the hospitals in successfully seeking legislation to permit productivity adjustments that would reward hospitals that had come into the system with relatively low costs in comparison to other similar institutions. In another instance, the hospitals sought to eliminate the CON program. The Commission's vigorous objections led to several compromise revisions in that statute. The hospitals' most ambitious legislative effort occurred in 1986, when the industry had a bill introduced that would have repealed the entire financing statute. After a 12-hour hearing at the Augusta Civic Center, the only venue large enough to accommodate all of the

hospital staff, trustees and patients whose attendance had been encouraged by the industry, the Joint Committee on Human Resources voted the bill "ought not to pass," and the system remained essentially intact.

The continuous criticism of the system led ultimately to the establishment, in 1987, of the Blue Ribbon Commission on Health Care Expenditures. The Blue Ribbon Commission, whose membership included representatives of the major special interests affected by hospital regulation and several legislators, provided a forum for the industry's concerns. Its deliberations led to legislation that continued the Health Care Finance Commission, but which mandated several significant changes in the regulatory program, most responsive to the issues discussed above. The revamped system, according to its advocates, was designed to allow whatever competitive forces exist within the hospital sector to operate more freely. Thus, there is greater sensitivity to volume changes in the new system: Most hospitals (except those in the more isolated areas of the state) are compensated for the impact of increases or decreases in patient volume in the year in which the change occurs. This change responds to the interests of growing institutions, and, indeed, rewards growth, while it reduces the negative impact of volume changes on small, rural hospitals. Capital costs now are essentially passed through to financial requirements, with capital expenses based on depreciation and interest rather than principal and interest. Although the contentious "unforeseen events" provision of the statute was repealed, a "variable adjustment factor" was introduced, requiring an annual add-on to financial requirements for changes in technology, medical practice, and unmeasurable shifts in severity of illness. This provision responds to the industry argument that the original statute and the Commission's rules were inadequately responsive to "subtle changes" in hospital costs. Provision was also made for a "standard component" that adjusts financial requirements to compensate for variations in cost per case among hospitals within peer groups. Finally, a pool for subsidizing bad debts, charity care, and governmental shortfalls was established to relieve these upward pressures on charges. The pool, funded out of the state's general revenues, received an appropriation in its first two years. State budget crises in later years precluded the appropriation of any new monies.

Impact on the commission

As a consequence of the industry's negative response to the regulatory system, the Commission was continually embroiled in time-consuming and distracting conflicts. (Hospital administrators doubtless would make the same claim.) While the Commission largely ignored the public relations challenges mounted by the hospitals, perhaps to its own detriment, it could not ignore challenges either through its own processes, through the courts, or in the legislature. The staff became mired in the details of notices of contest. The commissioners listened to oral arguments, waded through briefs and hearings records, and deliberated for hours at a stretch. Each spring found the executive director and general counsel defending the Commission's positions at legislative committee hearings and work sessions. With increasing frequency, the general counsel appeared in court.

The Commission did not overtly devise a strategy for addressing its problems. Yet an implicit strategy developed. The inclination was to protect the integrity of the payment system in light of its principal goal of cost containment. In practice, this meant fending off any initiative that would

unduly raise financial requirements. The staff responded to notices of contest with firmness and rigor. The Commission stuck firmly with the rules, almost always supporting the interpretations of the executive director. Adherence to the requirements of the APA was religious. Before the legislature, the Commission's representatives took pains to explain as clearly as possible the implications of all proposed legislation. Pressed for time and disinclined philosophically to engage in public relations activity, the Commission limited its defense to occasional speeches by the executive director and commissioners before hospital groups and other directly interested forums.

As the number of formal cases filed with the Commission proliferated, a kind of *de facto* budget review process developed, which coexisted with the formula-based system and was administered by the same staff. Aside from the sheer burden of many formal cases, the staff lacked what would have been a key element in a formal budget review system: the option of reviewing and rejecting those portions of a hospital's budget not under contest. The adjustments sought by hospitals were always for higher financial requirements, so any settlement would increase hospital revenues, regardless of how inefficient the institution otherwise might be. The staff's reluctance to settle was understandable. These considerations, along with the press of other business, generated a large backlog of cases that, in turn, became a liability for the Commission. The long list of outstanding cases, which only recently have nearly all come to settlement, afforded the hospitals the argument that the system was needlessly complex and difficult to administer.

The enormous case load tested the internal structure of the Commission. For purposes of adjudicating cases, the Commission's staff had been divided into two components: the hearing examiner and staff (consisting of an attorney and one or more advisory staff), and the executive director and legal counsel and staff. Informal communication (*i.e.*, communication in the absence of all of the parties to the case) between the examiner's group and the advocacy group on issues directly related to a formal case was forbidden. This approach, while probably the only acceptable course of action, had its costs. Insights into the practical workings of the payment system, learned on the legal side in the course of an on-going case, could not be transferred readily to the policy side, and vice versa. These difficulties may have weakened the administration of the system.

An imbalance of forces

In the political arena, a number of factors, most not unique to Maine, but in some cases exaggerated in Maine's economic and political climate, weighed heavily in the hospitals' favor.

A growing economy. The adverse political climate facing the Commission may have been worsened because it was attempting to restrain hospital revenues in the context of a growing economy. Pressure on the state budget moderated substantially during the mid- to late-1980s as rapid economic growth generated new tax revenues. The initial motivation to control the growth in Medicaid costs was mitigated. The blossoming economy did not provide a political climate of support for regulation. If everything else was growing during the Commission's early years, why should not hospitals share in the growth? The addition of \$7.8 million by the legislature to the Hospital Development Account seemed symptomatic of this kind of thinking.

Citizen legislature. The statute creating the Commission was approved overwhelmingly by both houses of the legislature. Despite the continued support of key Human Resources Committee members, the consistent opposition of the hospitals began eventually to take their toll on the Human Resources Committee's patience. The complexity of the regulatory system made it difficult to explain and defend. For instance, when hospitals would argue that they were increasingly experiencing operating losses, the Commission would have to explain that in many instances total margins were still positive and that accounting losses did not accurately reflect cash flows. While Committee members understood the issues, the necessity of long and convoluted explanations was troublesome as the issues resurfaced from session to session. Contributing to these problems, the rate setting statute failed to set any standards by which the success of the system might be measured. Statutory intent was clear enough, but there was no yardstick to gauge effectiveness. The Human Resources Committee became impatient with the hospitals as well as with the Commission. Some Committee members expressed the hope that some basic changes in the system could "fix" it well enough that the Committee could attend to business other than hospital regulation. In this vein, the Committee endorsed the idea of a Blue Ribbon Commission to evaluate the regulatory program and to propose "reforms" in the system.

Special interests and the public interest. The beneficiaries of effective regulation are the state's citizens and their employers, who would pay lower taxes and health insurance premiums. The individual citizen, however, has little incentive to participate in the political process. The cost of becoming adequately informed about the complex issues of hospital finance and the cost of participating in a citizen lobbying effort could easily outweigh the benefits that a citizen might reasonably expect to follow from his or her own action. The potentially concerned citizen has incentives to be a "free rider" who lets others bear the cost of political activism. The authors can recall, with perhaps a single exception, no Commission hearing or discussion session and no legislative hearing or work session at which a citizen was evidently present without the sponsorship of one special interest or another.

Moreover, the savings generated from cost containment are largely invisible. Cost containment of the modest sort pursued in Maine limits the growth in costs rather than lowering them. It is difficult to persuade voters by the argument that costs, although rising, are lower than they otherwise would have been. And increases in hospital revenues attributable to legislated increases in financial requirements do not have the same immediacy as tax increases. While legislators might well have been uncomfortable raising \$7.8 million in taxes to finance hospital expansion, they seemed to have few qualms about raising financial requirements by the same amount.

The Commission did have organized supporters. Among its early allies were Blue Cross/Blue Shield of Maine and the health insurance industry lobby. Just prior to the creation of the Commission, Blue Cross and the hospitals had failed to agree to continue their long-standing contractual relationships, which had been built on a negotiated differential that gave Blue Cross a very favorable position in the market. Blue Cross may have seen the regulatory program not only as a way of relieving pressure on premiums by controlling costs, but also as a means of continuing its discount through regulation. But the differential ultimately approved by the Commission was only a fraction of that which Blue Cross commanded prior to the creation of the payment system. Thereafter, the Blue Cross commitment to the Commission's program, though

always present, appeared to be somewhat lukewarm. UNUM (at the time, Union Mutual) was initially an active supporter of regulation, but lost interest when it left the health insurance market. The Commission's supporters also included elements of the low-income lobby (often in the form of Consumers for Affordable Healthcare), the labor lobby (in the form of the Maine AFL-CIO's Maine Labor Group on Health) and representatives of the elderly (the Maine Committee on Aging).

On the other side of the conflict was the organized political force of the hospital industry. The Maine Hospital Association served as the industry's principal lobbyist and organizer of opposition, and it eventually enlisted the organized support of hospital trustees. The Commission was initially able to garner some support from the small, rural hospitals which were being particularly hard-hit by a growing Medicare shortfall, by decreasing admissions, and by increasing competition from the regional medical centers (and in some instances from among themselves). The Commission argued with some success that its program favored these troubled institutions, since no downward volume adjustment was made during the first two payment years and since the formula determining revenue limits ensured coverage of financial requirements despite Medicare shortfalls. But despite their numbers, the small hospitals were not a sufficiently powerful force within the industry to sway the hospital association's position. And as time passed, regulatory benefits for small hospitals diminished. As the Commission began to implement annual volume adjustments, small institutions found themselves without the flexibility to make the needed reductions in expenses in response to lower approved revenues. Further, some small hospitals faced market circumstances that were so adverse that they simply could not levy charges as high as those authorized by the Commission. Thus, a support source from within the industry was eventually lost.

In Maine, a hospital rate regulation program may be particularly vulnerable to political attack because of the underdeveloped nature of the state's rural economy. Many hospitals, indeed, even those in Maine's major cities, are the largest employers in their communities. They are an export industry that creates employment in response to demand from outside the community. Some supplies and many services are purchased locally, which pumps money into the local economy. Politically influential local business people thus have a financial stake in the viability of the local hospital. The traditional philanthropic orientation of a community towards its hospital and the value that people place on the ready availability of hospital services both buttress this concern. The hospital industry contrasts sharply with public utilities, such as electric power companies, whose resources are concentrated in only a few locations. The utilities do not have support groups such as local trustees and "auxiliaries" scattered throughout the state's electoral districts.

Lack of gubernatorial support. The Commission was created at the initiative of and with the vigorous support of then Governor Joseph Brennan and the leadership of the Department of Human Services. Continued support was not forthcoming from the new administration. Governor McKernan and his Human Services Commissioner both seemed disposed against regulation. The Commission would have preferred to size the Hospital Development Account in the context of a state health plan, but the Department of Human Services curtailed the planning process. The Commission also would have welcomed the support of the Department for its efforts to constrain the sizing of the Development Account by reference to the standard of affordability.

Ambivalent business interests. The weakness of political support for hospital regulation in Augusta was exacerbated by the lack of support for that regulation by the state's business community. The organized business community always displayed an ambivalent stance toward the regulatory program. In other states that took a firm stand on hospital cost containment, such as Massachusetts and Maryland, powerful business/labor coalitions supported health care reform. Maine had no such group. Business leaders recognized that high health care costs might be a deterrent to new industry or a threat to their competitive positions. They were obviously aware of the rapid increase in group insurance rates. On the other hand, business leaders often serve on hospital boards and are naturally skeptical about regulation. This ambivalence apparently precluded the possibility of strong support for the Commission. As the Blue Ribbon Committee deliberations developed, business representatives generally supported the hospitals.

Other factors. Several other considerations contributed to a less than supportive political environment. Maine may have lacked circumstances that in others states made rate regulation more politically viable. In Maryland, whose regulatory system served in part as a model for Maine's (although there are important differences), large, urban hospitals were facing financial difficulties which would be mitigated as the state required payers to pay rates sufficient to cover each institution's financial requirements. The Maryland system was created with the support of these hospitals. The Maryland rationale was simply irrelevant to Maine's larger, urban institutions which, for the most part, entered the system during a period of prosperity and growth. Further, in contrast to Maryland, Maine implemented its regulatory system at a time when the state was not alarmingly above national averages in terms of per capita hospital expenditures. The Commission has argued that per capita comparisons are misleading because they ignore Maine's low income and that affordability is really the central issue.

Finally, because Medicare implemented PPS at roughly the same time that Maine created the Commission, the credibility of the new payment system may have been weakened. Pursuit of a federal waiver of Medicare payment regulations would have been so obviously fruitless that the payment system never covered all payers, as was originally intended. Medicare's failure to cover its portion of rising financial requirements led to increases in charges to the non-governmental payers that far exceeded increases in costs, which created the appearance that the system was ineffective in controlling the growth in insurance premiums regardless of its ability to control costs.

Reprise and prospective

The success of a new regulatory program depends as much on its political feasibility as its technical merit. Technical soundness is essential for a program's success, but it is not sufficient to ensure its viability. On the other hand, a regulatory program may be politically viable even if it is technically ineffective: It will simply not engender any industry opposition. The key question, then, is this: When can a technically effective regulatory program be politically viable? There are two possibilities: Either the program has sufficient countervailing support to withstand attack from the regulated industry, or the industry agrees, at least tacitly, to accept regulation. As regulatory economist Alfred Kahn has observed, the latter situation can arise when an industry sees some compensating gain from the existence of the regulatory program. (Testimony in Maine Public Utilities Commission Central Maine Power Company Docket N. 84-120.)

The evolving political and economic environment in which the Commission and the hospital industry function may justify and assure the Commission's continued existence, perhaps in modified form, for both reasons. First, despite the criticism the Commission has endured over the years, it has managed to survive and to accumulate a credible record of cost containment. As indicated in its most recent annual report, hospital charges, hospital charges per capita, net patient service revenue, and net patient service revenue per capita all have risen in Maine over the period 1984-91 at rates far less than regional and national averages. The Commission estimates that "...if Maine hospitals had experienced increases in their net patient service revenue equal to those of the United States for the period from 1984 through 1991, instead of the increases allowed under Maine's hospital payment system, they would have collected an additional \$168.7 million over the period." (Maine Health Care Finance Commission, Annual Report, 1992.) At least for the period covered by these data, it would appear that the forces that may have eroded its power have not rendered it completely ineffective in containing costs. The Commission's continued existence, despite substantial political opposition, probably reflects a fundamental acknowledgement by the public at large and by the legislature that the problems of rising health care costs and inaccessibility to health care services simply cannot be solved without public intervention. With the attention currently focused on health care reform by the Clinton administration and by the press, this climate is likely to continue.

Secondly, the accumulated expertise of the Commission, including the staff's knowledge of the industry and its data base, are a logical core for any new state effort to expand access while containing the growth in costs. A state-level single-payer system could be built on the foundation that the Commission has already established. Alternatively, if the Clinton administration moves as anticipated to give states latitude in establishing programs built on the managed competition, the Commission could also serve a useful role. Maine is too small to support more than one buyer cooperative and that cooperative might well be a state agency. In this case, managed competition and the single-payer concept meld together. Again, the Commission would be the logical starting point if the state were to consolidate the planning, purchasing, and rate control functions into a single agency. In any case, the effectiveness of any new state-run program for expanding access and restraining costs would be challenged by the same forces that have challenged the Commission. For such a system to be viable, it must have the vigorous support of the legislature and the governor.

By an alternative line of reasoning, the hospital industry in Maine might come to accept rate regulation as serving at least some of its interests. Mandatory rate regulation was viewed with particular disdain during the 1980s, when conservative attitudes toward government prevailed and when the hospital industry argued that competition could solve the cost problem. (Indeed, the recommendations of the Blue Ribbon Commission, which have only recently been fully implemented, were based on this assertion.) Competition is now out of vogue, and has been replaced with a new ethos of "cooperation" among providers. But cooperation among suppliers in any industry is justifiably suspect, since it poses the threat of price fixing and market sharing. State and federal anti-trust laws respond to these concerns, but recently health care providers have been seeking and receiving limited exceptions from these statutes. Such exceptions might be justified if rates are regulated to protect the public from anti-competitive pricing policies. In exchange for providing hospitals more flexibility in pursuing cooperative development strategies, the public reasonably deserves two things: effective rate regulation and appropriate

constraints on the rate of expansion of hospital services and plant and equipment. Maine's current regulatory program is well suited to engineer this reciprocity. If the hospital industry and political actors both understand the Maine regulatory program in these terms, then the program may yet become an accepted and effective political-economic institution.

Some lessons

It is widely agreed that there is no guarantee that the hospital industry, when left on its own, will operate in the public interest by providing the right amount of services in the most efficient manner possible. Problems arise largely because consumers of hospital services are not informed buyers of hospital services. Doctors act as their agents, and hospital services are paid for overwhelmingly by third parties. Institutions such as the Commission are meant to compensate for the market's failures. Effective rate regulation would assure that the right amount of resources flow into the industry and that suppliers do not earn excessive profit. Thus, agencies such as the Commission are really an alternative means of making important social choices that cannot be left to the market. The weakness of such agencies is their vulnerability to political influence. We have seen that vulnerability in Maine's experience with hospital rate regulation. Based on Maine's experience, we offer the following observations:

- Simplicity may be an important virtue. Complexity itself is a political liability. Regardless of the technical merit of a program, if it is not readily explainable to the public and to the legislator, or even to hospital administrators, it will be suspect. Simplicity will lower administrative and compliance costs and may also reduce the costs of adjudication.
- There needs to be an acceptance by the agency and by the political system of a few clear-cut and readily understandable standards of agency effectiveness. Establishing standards at the outset is a risky step for an agency to take. But if the agency succeeds by these standards, it will be better able to defend its performance.
- Third, a negative response from the regulated industry should be expected, and the agency should be prepared to defend its position in the political arena. To defend itself against the political response of an offended industry, the regulatory agency must be willing to nurture the agency's constituency by keeping its political sponsors and supportive interest groups well informed and by mounting an effective public information program. Program simplicity and well-defined performance standards would aid in these efforts.

Above all, if economic regulation of hospitals, and health care providers for that matter, is to work for Maine citizens, elected officials need to be willing to act as buffers between interest groups and the regulators. Effective regulation will nearly always offend the regulated industry; opposition should surprise no one. Supporters of regulation need to be prepared for a protracted defense of the regulatory agency. Absent an effective defense, the danger is that the regulatory program may end up serving the interests only of the regulated industry or acting as a smoke screen for economically inefficient industry performance.

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