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Addressing State Health Care Challenges through Regulation: Use of a Public Utility Model

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Introduction

As described by Nicholas Bagley in his 2015 "Medicine as a Public Calling," the debate over how to control medical spending often pits advocates of government interventions against those who embrace market-driven approaches.[1] The possibility of regulating the medical industry as a public utility is often dismissed as politically unfeasible, and in conflict with desires to maximize patient choice and physician independence, protect hospital financials, and minimize government interference. However, what goes unrecognized is the extent to which the public utility model has historically shaped health law. Not only is such an approach compatible with our governing institutions and political culture; it is beginning to play an increasingly important role in many states.[2]

In this article, we first review current health care challenges with respect to (1) supply; (2) access; (3) geographic variation in prices; and (4) costs. These are four areas highlighted by Bagley. We then discuss how the market approach has attempted, and often failed, to address these challenges, and describe an alternative framework for doing so—the public utility regulation model. Finally, we detail the current landscape of public utility-like regulation efforts in several leading states, including the use of the public utility model for health care, how states can use the model, examples of related state efforts, and what the information presented means for Connecticut.

State Health Care Challenges

The Affordable Care Act (ACA) has helped to address many of the US health care system's shortcomings—most notably, by extending affordable coverage to millions of Americans who were previously uninsured or underinsured. However, many challenges remain. These challenges include: (1) lack of adequate primary care provider supply, particularly in rural and poor urban areas; (2) inadequate access to providers, often resulting from restricted coverage networks; (3) wide geographic variation in medical prices, driven in part by differences in provider market power; and (4) escalating medical costs, which are difficult to mitigate due to concentrated market power.[3] Even in a post-ACA environment, these challenges will likely persist.

Three Approaches to Addressing Health Care Challenges

Market-based approach

A market-based approach to health reform is often lauded by the political right, which tends to see government rules and regulations as interfering with achieving maximum efficiency within the industry. Examples of market-based approaches may be found in consumer-directed health plans, where high levels of patient cost sharing curb unnecessary (and necessary) utilization; in health insurance exchanges, where health plans "compete" for enrollees on cost and quality; and in provider settings, where hospitals and physicians "compete" for patients through delivering lower cost and higher quality care. In theory, this competition controls costs while maximizing quality. However, the health care industry often fails to meet the conditions necessary for a free and ideal market. For instance, competition fails when a health plan or provider dominates a local market, or when information about cost and quality is not accessible to patients. Additionally, information asymmetries often lead to supplier-induced demand when physicians have greater information than their patients. Health insurance also shields individuals from the true cost of care and thus cost is not fully understood or used in patient decision-making.[4 5]

Single payer

Some groups on the political left have historically responded to market failures by endorsing a single payer system, sometimes referred to as "Medicare for All." Single payer proponents envision a high degree of direct and indirect regulation of the health insurance industry and providers. Under such a system, a single government or quasi-public entity would collect all fees and pay all costs to hospitals and other providers, using budgeted funds collected through payroll or other taxes. However, interest in and feasibility of such an approach has waned over recent decades and is unlikely to resurface any time soon, given the forward momentum of the ACA.

Public utility regulatory framework

In practice, the country has found middle ground that embraces government regulation to varying degrees to address the shortcomings of market-based approaches, while avoiding the strict market control of single payer. For example, states license providers of care and regulate medical facilities. State law informs legal deliberations over medical malpractice. Federal law requires hospitals to treat and stabilize patients in emergency departments, and protects patients from unnecessary sharing of their medical information. Neither a complete free market nor single payer approach, "public utility regulation offers a less disruptive alternative, one that retains the basic architecture of the private financing system while asserting state control over the medical industry's perceived excesses."[6]

A Public Utility Framework for Addressing Health Care Challenges

For public utility regulation to be considered appropriate within an industry, or rather, for that industry to be "affected with public interest," early courts and legislatures agreed that two conditions should be met: (1) that the industry meets "an important human need" (i.e. necessity); and (2) some feature of the market presents a "risk of oppression" (i.e. power).[7] Although the definition of necessity is broad, it has been defined as a good or service on which an individual is dependent to a "substantial degree" or one that "contributes to a psychologically full life."[8 9] Necessity can apply both to individuals and to society broadly, as it has been linked historically

to "the economic and social development of the broader community," as seen with banks and insurance.[10]

In addition to necessity, power is a defining condition of an industry "affected with public interest." Here, laws and regulations are used to protect against monopolistic power. The idea of monopolistic power may apply to features within a market, such as bargaining inequalities or information disadvantages, and is not confined to natural monopolies.[11] [12] Instances where "consumer disadvantage" or "widespread oppression" would arise in a market are viewed as monopolies of political power, from which the public should be protected.[13] [14] In response, public utility regulation "became the dominant governance strategy for managing important industries that neither the market nor antitrust law could adequately discipline."[15] [16]

Medicine was long absent from the list of industries affected with public interest. However, throughout the 20th century, as medicine transitioned from a "luxury to a necessity" and as the industry "acquired the power to abuse its control over a necessity," courts then considered it to be such.[17] [18] [19] Supporting the concept of protecting patients in these "desperate markets," many examples of laws can be cited that center around the four duties of businesses affected with a public interest: to provide enough facilities to meet the public need (supply); to serve all paying customers (access); to charge them nondiscriminatory rates; and to offer a fair price (cost).[20] These laws have borne and still do bear many characteristic features of public utility regulation.

Today's hesitancy toward regulating medicine as a public utility does not arise from lack of success with the approach. In fact, experience in other countries, such as Australia, Denmark, France, Germany, and the Netherlands, suggests that government regulation of providers and payers can work well to reduce costs while maximizing quality of care.[21] [22] [23] However, there is a general perception that public utility regulation is "rarely adopted and used only as a last resort."[24] Typically, regulation is used in markets with natural monopolies, and this practice often inappropriately excludes medicine because of its fragmented, complex system of hospitals and providers. What goes unrecognized, however, is the extent to which the public utility model has historically shaped health care. Starting in the mid-1940's "as medicine became technologically more sophisticated and acquired substantial market power… policymakers began drawing on the public utility model" to address challenges that began to plague our health system: supply, access, discrimination, and unfair pricing.[25]

The Current Landscape of Public Utility Regulation in State Health Policy

Why states should consider the public utility model for health care

Despite some skepticism, forms of public utility regulation in health care have been used in conjunction with market forces for decades. Many provisions of the ACA focus on regulating and reshaping health insurance markets, but "states retain the authority to regulate hospitals, physicians, and other providers."[26] States may do so by embracing public utility regulation to address issues such as price and access.

How states can use the model

Historical examples of public utility regulation in health care have included health planning, certificate of need (CON) legislation, and emergency care obligations for hospitals, among others.

However, the next generation of regulations may take on their own form, including possible reforms to CON laws "to more closely superintend provider consolidation, the construction of expensive facilities, or the acquisition of novel technologies."[27] Enactment of legislation that requires health plans to accept any willing providers into their networks may also be of interest to states; some have already considered doing so. Closer oversight of provider networks and patient protections against unexpected out-of-network bills are other possibilities. Also, states may want to "establish commissions to monitor provider prices and perhaps even fix rates."[28] Additional examples include establishment of an all-payer claims database (APCD) as a regulatory tool, all-payer rate regulation, capitation of statewide annual health care cost growth, and improved public cost reporting and transparency.

Examples of state regulation efforts

Maryland. Since 1977, Maryland has operated the only all-payer hospital rate regulation system in the nation, as permitted under a Section 1814(b) Medicare waiver. In 2014, Maryland proposed to deliver better care and lower costs by testing a new model that aims to modernize its all-payer rate setting system. Under this model, rather than setting Medicare payment per inpatient admission, the state will use Medicare per capita total hospital growth. Annual hospital growth will be limited to 3.58 percent, thus establishing fixed budgets for hospital systems, and $330 million in savings must be generated over the five year performance period. Quality targets related to readmissions, hospital acquired conditions, and population health must be achieved as well.[29]

Massachusetts. Massachusetts has long been a leader in state health reform, with enactment of major legislation in 2006 that closely resembled many of the provisions laid forth in the ACA. In 2012, the state adopted sweeping cost control legislation that aimed to save nearly $200 billion over the following 15 years by capping state health care cost growth at the growth rate of the state's economy.[30] It aimed to do so through promotion of Accountable Care Organizations (ACOs) and alternative payment strategies such as capitation and bundled payments. Also, the law "mandates the use of electronic medical records (EMR), and bulks up state government oversight and involvement in the health care marketplace" through the creation of two new entities: the Health Policy Commission and the Center for Health Information and Analysis (CHIA).[31]

The Commission is given the authority to oversee state spending targets and review providers with "excessive expenditures" should the state exceed its spending target.[32] [33] In 2014, the Commission provided a detailed analysis of the consequences of Partners Healthcare System's proposed acquisition of South Shore Hospital and Harbor Medical Associates.[34] Ultimately, the attorney general rejected the deal due to concerns about unacceptable increases in market power.[35] CHIA is an independent state agency charged with "total health care cost data collection and analysis."[36] In these efforts, they monitor data and provide analyses on which state health reform efforts can be built.[37]

Oregon. In 2009, Oregon enacted legislation to create the Oregon Health Policy Board (OHPB), which oversees the health care transformation activities of the Oregon Health Authority and develops health policy recommendations for the state.[38] At the center of their cost containment strategy have been coordinated care organizations (CCOs)—defined as "a network of all types of health care providers (physical health care, behavioral health care and sometimes dental care

providers) who have agreed to work together in their communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid)."[39] There are currently 16 CCOs statewide, which began to launch in 2012 under an 1115 waiver.[40] The goal of this care model is to reduce Medicaid costs while improving quality and access. For the second year in a row, the model is showing promising cost and quality results.[41] Following these early successes, the state is next looking to measure total costs, align care models for additional payers and populations, and develop policies "to increase cost transparency, reduce cost shifting, and control insurance rates."[42]

Vermont. Vermont is another state that has historically been years ahead of others in efforts to expand access, control costs, and improve quality. The Vermont Blueprint for Health, "launched in 2003 and codified into law in 2006,"[43] is described as "a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care cost by promoting health maintenance, prevention, and care coordination and management." The foundation of the program is a medical home model supported by community health teams. Program results suggest that participating Blueprint practices have lower total expenditures per capita for both private and Medicaid patients and have lower overall utilization rates, compared to a comparison group.[44] Furthermore, Act 48 of 2011 established Vermont's Green Mountain Care Board (GMCB), which is charged with reducing "health care cost growth to a sustainable rate" and ensuring "a high-quality health care system that promotes the well-being of Vermonters," through regulation, innovation, and evaluation.[45]

Since fiscal year 2013, review of Vermont's hospital budgets had been regulated by the GMCB.[46] The reviews are guided by Hospital Budget Rule 3.000, which promotes improvement of population health, reduction of per capita rate of growth across all payers while protecting access and quality, enhancement of patient experience, recruitment and retention of quality providers, and administrative simplification of health care financing and delivery.[47] The GMCB also reviews Certificates of Need and insurance rates, supervises projects that test payment and delivery innovations, and measures and evaluates the effects of these efforts.[48] Some of the payment models currently being evaluated include bundled payments, hospital/physician global budgets, and global payments.[49] Additional state cost strategies underway include setting overall limits on cost growth, setting ACO payment standards for Medicaid and commercial payers, and establishing a total health care budget and provider rate setting, which has been authorized but not yet implemented.[50] Many of these strategies are also integrated into Vermont's State Innovation Model (SIM) grant—a $45 million grant awarded in 2013.

Rhode Island. In 2004, Rhode Island became the first and only state to establish an Office of the Health Insurance Commissioner (OHIC), recognizing that the health insurance market was unlike other insurance markets in the state. OHIC is charged with regulating and monitoring health plans, creating new regulations and updating existing ones, and working with stakeholders to ensure that proposed reforms are "practical, relevant, and fair."[51] OHIC also oversees rate review, plays a large role in consumer protection, and has played a pivotal role in pushing for health system change. In 2009, the Commissioner cited broad statutory language that created OHIC to mandate that insurers (1) spend more on primary care (an increase of one percentage point of

total spending for five years); (2) better manage care for individuals with diabetes and chronic conditions, which was done under establishment of a statewide multi-payer medical home program; (3) use EMRs to reduce unnecessary utilization and identify high risk patients; and (4) move towards payment systems that pay for quality rather than quantity.[52]

More recently, in response to rising health care costs, Rhode Island has established a Working Group on Healthcare Innovation. The Group "will provide recommendations to establish a global health spending cap for Rhode Island, tie 80 percent of health care payments to quality by 2018, develop a next-generation health information technology system for all payers, and establish performance management frameworks to achieve population health and wellness goals."[53] As part of this effort, earlier this year, the state's Working Group to Reinvent Medicaid has developed a series of recommendations that identify more than $90 million in FY2016 general revenue budget savings.[54] Other recent achievements in the state include a statewide Health Information Exchange, as governed by the Rhode Island Health Information Exchange Act of 2008, and an All-Payer Claims Database.[55]

What's next for Connecticut

Connecticut, among other states, is facing concerns with skyrocketing insurance prices.[56] Average health care expenditures per capita were $8,654 in 2009—the third highest amongst US states.[57] Meanwhile, hospitals and health systems have faced notable consolidation in recent years. Historical experience suggests that such consolidations can drive up prices and the total cost of care.[58]

The state has taken some measures to regulate the health care market in an effort to reduce costs and improve quality. For instance, in 2015 the state enacted legislation (S.B. No. 811, Public Act No. 15-146): "An Act Concerning Hospitals, Insurers and Health Care Consumers."[59] The Act has provisions that focus on (1) disclosure of fees and affiliations for hospitals and physician practices; (2) new rules in the approval process for hospital sales; (3) establishment of a statewide health information exchange to securely share medical records in real time across providers; (4) promotion of price and cost transparency, and (5) protection of patients against surprise bills from out-of-network providers. The legislation also charges two groups with studying issues related to state health care costs and price variations.[60]

International and progressive state experience with public utility-style health care regulation demonstrates that reforms leading to greater access, lower costs, and higher quality of care are well within reach. Further public education and legislation will be necessary for Connecticut to join the ranks of progressive states leading the way in health system transformation and improving the health of residents.

Authors

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