

# Rate Regulation Revisited: Managing Regulatory Failure and Regulatory Capture in Health Care

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## ABSTRACT

Concern over high and rapidly rising hospital prices has increased interest in government regulation of health care prices. However, regulation of health care faces two potential weaknesses: regulatory failure (intrusive regulations that can increase an industry's cost both directly and by reducing incentives to improve operating efficiency, pursue innovation, or address equity and disparities) and regulatory capture (regulators serving the interests of the regulated industry rather than the public interest). To investigate the threats posed by regulatory failure and capture and to identify approaches that can minimize or ameliorate the effects of these two phenomena, we conducted a review of published literature and consideration of past regulatory strategies and structural features. We found that although the dangers of regulatory failure and capture are real, they are manageable. The use of structural features that protect the independence of regulatory agencies, coupled with development of fully transparent pricing systems that are not overly complex, can help prevent or reduce the incidence of regulatory capture and failure.

## INTRODUCTION

Health care markets in the United States are characterized by various forms of so-called market failure. Of all the imperfections in U.S. health care markets, one of the most important is the consolidation of health care providers, particularly hospitals and health systems, which has created noncompetitive conditions and given provider entities unprecedented levels of market power to negotiate monopoly prices.<sup>1</sup>

Due to the presence of market failures, particularly provider and insurer concentration, commercial health care markets do not work efficiently, and prices are far higher than either the average or marginal cost of production. Research shows that these dynamics are primarily responsible for the rapid growth of commercial prices and spending in recent years, which has greatly eroded the affordability of health care for individuals and households in recent decades.<sup>2</sup> The failure of the market for health care services invites some form of government intervention.

While empirical evaluations of rate regulatory systems have shown that these approaches can successfully constrain health care price growth and meet other policy objectives,<sup>3,4</sup> many economists are wary of such government intervention because of concerns that rate regulation is vulnerable to regulatory failure and regulatory capture, which can create further inefficiencies and market distortions that are not in the public interest.<sup>5</sup> Others point to a range of strategies for minimizing the occurrence of these phenomena. States should adopt less complex, less interventionist, and more targeted rate regulatory approaches to minimize regulatory failure and institute structural remedies to help prevent regulatory capture.

## REGULATORY FAILURE

The concept of regulatory failure is associated with the idea that, even if a particular marketplace experiences market failure to some extent, government rate regulation may make matters worse rather than better.<sup>6</sup>

Regulatory failure may include:

- a lack of responsiveness by the regulating agency to changing market conditions,
- excessive complexity of regulatory methods that hampers the ability of the regulated industry to respond to the incentives and achieve the goals of the regulated system,
- regulatory rules or incentives that result in industry performance that is not consistent with the public interest, or
- the promulgation of regulations or governmental policies that result in prices that are too high or low and/or widely varying prices.<sup>7</sup>

These circumstances, which are particularly prominent in the U.S. health care system, can result in suboptimal allocations of resources and outcomes across the regulated industry.<sup>8</sup>

An example of regulatory failure in health care occurred in the New York Prospective Hospital Reimbursement Methodology (NYPHRM) system (the first state-based hospital all-payer rate-setting system in the nation), which was in place from 1971 to 1995. The state's rate methods were dominated by a need to reduce Medicaid deficits, resulting in regulators setting rates and annual rate updates at very low levels. This led some of the state's most prestigious and critical hospitals to the brink of financial ruin in 1977 and 1978.<sup>9</sup>

During its latter years, NYPHRM was considered incomprehensibly complex, having undergone five different legislative overhauls.<sup>10</sup> When a regulated price system is both very complex and modified frequently, and particularly when these changes are initiated and influenced by powerful members of the regulated industry (an example of how regulatory failure can contribute to regulatory capture), the rate-setting agency comes to be viewed as arbitrary and politically driven rather than an unbiased policymaker that prioritizes the public interest.<sup>11</sup> Indeed, the methodology of the all-payer systems in New York became so complex in the late 1980s that only a small group of regulators and hospitals fully understood it.<sup>12</sup>

Another form of regulatory failure, which was prevalent in Washington State's failed attempt to operate an all-payer hospital rate-setting system, is a regulatory agency's tendency to micromanage the regulated entities and the entire regulatory process. While Washington's enabling legislation was nearly identical to a statute adopted in Maryland, the two states differed dramatically in how regulators chose to operate their systems, with Maryland opting for a system that used well-understood formulas to update rates more or less automatically each year. The Maryland system also attempted to minimize regulatory intrusions and regulatory micromanagement by focusing regulatory intervention only on outlier institutions (e.g., hospitals that deviated significantly from the cost standards established by the Maryland Health Services Cost Review Commission [HSCRC]).

By contrast, Washington's system relied on an excruciatingly detailed and highly contentious annual budget review and approval processes for each hospital in establishing rates for each year. Even though the approved annual updates provided by the Washington rate commission were extremely generous and the rate of inflation in hospital costs in the state exceeded the national average over the period of the regulation, the hospital industry was antagonistic toward the regulatory system and in 1989 managed to bring it to an end. Such antagonism is an almost inevitable outcome of a system of overly intrusive regulation. Excessively detailed rate-setting interventions inappropriately substitute the judgment of regulators for the judgment of hospital administrators regarding key resource allocation decisions and thus tend to antagonize administrators who feel their authority is being undermined.<sup>13</sup> Such micromanagement activities cause a regulator to lose sight of the larger goals of a regulatory system, which is to meet its primary policy goals while minimizing the level of regulatory intervention.

## REGULATORY CAPTURE

Although regulatory failure is perceived in the U.S. as a more pervasive phenomenon than regulatory capture, much of the literature on rate regulation contains descriptions and assessments of regulatory capture, along with prescriptions to help prevent or mitigate its deleterious effects. Regulatory capture is the process through which regulated entities successfully influence and even manipulate government agencies to enact policies that advance their own special interests over the interests of the broader public. The motivation for the capture of the regulatory agency is an industry's desire to use the regulatory process as a vehicle for charging higher prices, restricting output, raising profits, raising executive salaries, and/or protecting itself from competitors.<sup>14</sup>

The most radical version of the regulatory capture theory posits that regulation is proposed and supported by regulated industries as a mechanism for supplanting competition with a legal, enforceable cartel.<sup>15</sup> Often-cited examples of this extreme form of capture are the much-maligned Interstate Commerce Commission (ICC), which worked to protect the railroad industry, and the Civil Aeronautics Commission, which was alleged to have set airline prices and restricted entry such that the major airlines were against deregulation of the industry in the late 1970s.<sup>16,17,18</sup>

In health care, instances of regulatory capture are often associated with the influence of the American Medical Association's Relative Value Scale Update Committee (RUC), which has been criticized for enabling specialty medical societies to dominate Medicare's development of physician payment levels to favor physician specialists and proceduralists.<sup>19</sup>

Other examples are the all-payer hospital rate regulatory agencies in New York, New Jersey, Massachusetts, and Maryland, which, after experiencing some early successes in containing hospital price and expenditure growth in the late 1970s and early 1980s, came under significant political pressure by hospital leaders to relax their cost constraints. This pressure led to methodology changes that allowed hospital rates and revenues to increase more rapidly in

the late 1980s and early 1990s, which contributed to large increases in hospital profitability during this period.<sup>20</sup>

The Maryland hospital rate-setting system also shows evidence of some degree of regulatory capture in recent years. Although the system has met the cost growth targets as required per the terms of the state's waiver from the national Medicare reimbursement system, regulators have set rates at levels allowing the hospital industry to generate operating profits hovering around 8% on regulated services since 2015.<sup>21</sup> This level is in excess of hospital profits nationally, which have been at all-time highs in recent years.<sup>22</sup>

## PRIMARY TYPES AND CAUSES OF REGULATORY CAPTURE

The literature classifies regulatory capture as either "materialist" capture or "cognitive/cultural" capture. Materialist capture can result from bribery or so-called revolving doors (the practice whereby regulators eventually leave government positions to take jobs in the industries they regulated). Fortunately, cases of bribery are likely infrequent and can be easier to uncover and punish, and the revolving door phenomenon can at least in theory be addressed by placing restrictions on the ability of regulatory staff to work for regulated entities for a period after leaving the agency.<sup>23</sup>

Cognitive capture can be more difficult to detect because it does not require an explicit quid pro quo between regulators and regulatees. Instead, the implicit prospect of a high-paying industry job may subtly influence a regulator to favor industry positions and objectives.<sup>24</sup> Cognitive capture is perhaps the most concerning type of capture and may be more difficult to prevent. It stems from the nature of personal interactions between members of the regulated industry and the regulating agency, in which the regulated industry perpetually attempts to persuade the regulator to adopt or modify existing methods that promote the industry's financial interests. This type of capture is a function of both the way in which these regulators and regulatees interact (e.g., in public or in private) and the frequency of their interactions.<sup>25</sup> It can also come as a result of an imbalance in the knowledge and expertise of regulatory staff relative to the knowledge and expertise of industry participants. This imbalance is particularly prevalent in highly technical industries such as financial services and health care.

Frequent interactions between the regulator and the regulated industry may cause the regulator to identify with the perspectives and preferences of the regulated industry.<sup>26</sup> Such regular exchanges between agency and industry can blur what should be a sharp line between regulator and regulatee and can compromise independent regulatory judgment.<sup>27</sup>

An example of cognitive capture may have been the development, at the request of the Maryland Hospital Association in the early 1990s, of ongoing agency/industry work groups on methodology development and major rate-setting decisions, including the magnitude of the HSCRC's approved annual inflation increase to hospital rates or global budgets. These work group activities were time-consuming for regulatory staff and made rate-setting staff the focal point for attempts by hospital lobbying to influence policy.<sup>28</sup> Such interactions

also caused frequent revisions to existing rate methodologies, adding to the complexity of Maryland's rate-setting system. In recent years, the agency leadership expanded these work groups to 16 in total.

While these work groups also included payer representatives, the overwhelming majority of attendees were from the regulated hospital industry and arguably unduly influenced the views of key rate-setting staff.<sup>29</sup> Frequent modifications of rate methods in response to ongoing lobbying of rate-setting staff by industry personnel usually add to the complexity of already complex systems.<sup>30</sup> Frequent changes to rate methods will add unneeded complexity that can obscure the financial incentives of the rate-setting system for hospitals and payers, and create inconsistencies in the rates applied to different hospitals, and open the door to legal challenges by the regulated industry. All of these factors can undermine the transparency and effectiveness of the rate-setting process.

## AVOIDING REGULATORY FAILURE AND CAPTURE

Given the significant data requirements, inherent complexity, and dangers of regulatory capture and failure associated with state-based rate setting, some economists argue that very few states have the ability to establish and maintain elaborate health care provider rate-setting systems that will stand the test of time.<sup>31</sup> Yet, the literature on regulated hospital pricing systems documents the operations of several highly effective rate-setting systems that did not experience significant failure or capture.<sup>32</sup> The Rochester Hospital Experimental Payment Program (HEPP), an all-payer Medicare demonstration that ran from 1980 to 1987 and covered nine hospitals in upstate New York, and the early Maryland all-payer rate regulatory system, which ran from 1976 to 1990, were examples of rate systems that largely avoided the debilitating influences of regulatory capture and failure.<sup>33,34,35</sup>

In the case of the Rochester HEPP, success occurred in part because the rate methods and locus of regulatory control were focused on constraining aggregate hospital budgets, as opposed to regulating the prices of individual hospital services. This system was also largely formula driven and far less complex than other rate-setting systems. The literature on this unique rate-setting demonstration – and conversations with those involved – indicate that hospital global budgets were relatively easy to develop and administer, requiring a full-time professional staff of only six to administer the system. This form of macro-oriented and formula-based regulation made for a simpler regulatory system, which was easily understood by hospital and payer personnel and more easily explained to legislators and other policymakers.<sup>36,37</sup>

The early Maryland system also relied on macro-oriented rate-setting approaches involving the heavy use of financial incentives, the establishment of attainable and well-understood performance targets, minimized regulatory intervention, regulatory focus on the most costly hospitals, the use of formula-based rate setting, and avoidance of frequent changes to rate methods. Instead, it adopted a long-term regulatory perspective designed to address Maryland's cost problems over the long haul without resorting to drastic and destabilizing short-term regulatory action.<sup>38</sup>

Maryland’s long-standing emphasis on its key regulatory principles and policy goals of promoting patient access, payer equity, cost control, industry and regulator accountability, and system financial stability and predictability also helped guide the HSCRC’s policymaking process and avoid the tendency of regulators to micromanage the system. Maryland’s statutory flexibility was also invaluable to regulators in the development of new and innovative hospital payment systems and in adapting to the introduction of managed care in the late 1980s and early 1990s.<sup>39</sup> Thus, Maryland’s flexible statute enabled the HSCRC to adapt its system to accommodate managed care delivery system innovations and avoid the managed care experiences of other rate-setting states.<sup>40</sup>

In addition to establishing systems with more flexibility and macro orientation, states can use certain structural remedies to enhance the independence and transparency of regulatory authorities, thereby limiting regulatory capture and failure. These structural remedies are presented and discussed in Exhibit 1.

Exhibit 1: Features of a Regulatory Approach That Affect Risk of Capture or Failure

Category	Lower Likelihood of Capture or Failure	Higher Likelihood of Capture or Failure
<p><b>Agency type</b></p>	<p><b>Advisory without rate enforcement authority</b></p> <p>Examples: MedPAC, Massachusetts Health Policy Commission (HPC)</p> <p>Advisory agencies/commissions that do not have rate-setting authority are generally not subject to capture attempts by the industry because they lack the authority to enforce rate/expenditure constraints.</p>	<p><b>Operational with rate enforcement authority</b></p> <p>Examples: previous all-payer hospital rate systems, Maryland HSCRC</p> <p>Agencies/commissions with strong rate-setting authority will be subject to repeated attempts by the regulated industry to influence policy, methodology, and rate-setting decisions.</p>
<p><b>Agency structure</b></p>	<p><b>Independent public or quasi-public agency</b></p> <p>Examples: Rochester Area Hospital Corporation (RAHC), Maryland HSCRC</p> <p>An agency that is largely independent of state government may be less subject to influences to elevate state priorities over the priorities of the general public. Agencies that report to and are dependent on the executive branch or legislative budget appropriations may be more easily captured. Independent agencies can be a source of innovation — as was the case in Maryland from 1976 to 1990.</p>	<p><b>Agency housed in state’s Department of Health</b></p> <p>Examples: New Jersey, New York, or Massachusetts hospital rate-setting agencies</p> <p>Agencies housed in state government may be more easily influenced to prioritize state policy/budgetary priorities.</p>

<p><b>Representation</b></p>	<p><b>Prohibition on agency leadership affiliation/ties with regulated entities</b></p> <p>Examples: Massachusetts HPC, West Virginia Health Care Authority</p> <p>Strict prohibitions on affiliations with regulated entities can help ensure that agency decision-making is not unduly influenced by the priorities of the regulated industry and instead emphasize the goal of protecting the broader public interest over the interests and goals of powerful regulated entities or those of the regulated industry as a whole. Regulatory agency leaders can receive input from members of the regulated industry by accepting public testimony and comment letters from industry representatives.</p>	<p><b>Mixed representation including those with affiliation/ties with regulated industry</b></p> <p>Example: Maryland HSCRC<sup>a</sup></p> <p>While some may believe it is useful to have industry representatives appointed to the leadership of an agency to promote a cooperative rule-making atmosphere, some provider-based appointees may work to influence other leaders and staff to favor industry interests.</p> <p>This is particularly likely to occur when industry representatives have specialized knowledge of hospital operations and the rate-setting process itself, relative to other appointed agency leaders or agency staff.</p>
<p><b>Leadership characteristics</b></p>	<p><b>Use of volunteer leaders/commissioners</b></p> <p>Examples: Maryland HSCRC, Massachusetts HPC</p> <p>The appointment of individuals with strong health care policy backgrounds and expertise (such as academic health care economists) can assist the agency in maintaining a priority of protecting the broader public interest and avoiding capture. The use of voluntary agency leaders/commissioners as opposed to full-time employed members can allow the agency to attract high-caliber representation from business, labor, academic, or community/consumer-based organizations.</p>	<p><b>Employment of full-time leaders/commissioners</b></p> <p>Examples: New Jersey, New York, Massachusetts, and West Virginia hospital rate-setting agencies</p> <p>The use of full-time salaried leaders/commissioners makes it difficult to attract leaders with sufficient public policy expertise with an emphasis on civic duty and a strong priority to protect the public interest over the interests of the regulated industry or more parochial priorities of state government.</p>



<p><b>Accountability and disclosure</b></p>	<p><b>Establishment of and adherence to clear performance metrics or targets</b></p> <p>The use of stringent but attainable performance metrics (e.g., cost control, quality improvement, equity in payment) imposed by an external authority (such as the federal government) with periodic review of performance and the imposition of significant penalties for nonperformance can galvanize support for the agency’s success and help immunize it from capture or failure. Over time, the agency should evaluate its overall performance and revise its goals and objectives accordingly.</p>	<p><b>Absence of performance metrics or targets</b></p> <p>The absence of clear performance metrics or targets with publication of the agency’s performance on these metrics on a regular basis obviously reduces the accountability of the agency.</p>
<p><b>Leadership strategy</b></p>	<p><b>Highly professionalized agencies with strong independent leadership and frequent articulation of agency principles and goals</b></p> <p>Agency leaders that prioritize the public interest over “deal making” to placate influential industry representatives are able meet their objectives most effectively. Frequent articulation of agency principles, regulatory tenets, and policy goals can help guide more consistent agency decision-making over time.</p>	<p><b>Agencies that emphasize balancing perspectives among interests</b></p> <p>A more passive approach to leadership leads to compromises among private interests that favor the better-resourced parties rather than the advancement of the broader public interest. The absence of clear and repeated articulation of agency regulatory principles and goals may facilitate decision-making that favors special interests over the broader public interest.</p>

<p><b>Regulatory approach</b></p>	<p><b>Emphasis on minimizing regulatory intervention, adoption of more macro-level methodologies, avoidance of frequent changes to regulatory methods/rules, and adoption of a long-term perspective</b></p> <p>Agencies that take a more macro approach to regulation (i.e., use of less detailed and complex rate methods, applying regulatory focus primarily on the poorest industry performers, adoption of rate methods that minimize the scope of regulatory intrusions) and avoid frequent and highly disruptive modifications to rate methods are better able to avoid capture and failure.</p>	<p><b>Development of highly detailed, prescriptive and complex rate methods with frequent changes to these methods in response to industry criticism</b></p> <p>Agencies that implement highly detailed and complex methods and change these methods frequently risk obscuring the incentives of the rate system and making the rate-setting system subject to “insider” gaming and a lack of transparency to key interest groups and the public.</p>
<p><b>Funding and salary structure</b></p>	<p><b>Well-funded agencies with a separate salary structure for staff</b></p> <p>Agencies with funding that is independent of a politicized budget appropriation process (i.e., funding through mandated “user fees”) have flexibility to perform necessary duties, avoid regulatory gridlock (e.g., excessive delays in regulatory action), and hire an expert and professional staff. Adequate funding is also important to prevent the agency from being vulnerable to information asymmetry, whereby agency staff is disadvantaged, relative to regulated industry personnel, by a lack of technical knowledge.</p>	<p><b>Underfunded/underresourced agencies that must rely on the normal state salary structure</b></p> <p>Agencies dependent on a potentially politicized budget appropriation process in the state legislature are at risk of attempts by the regulated industry to starve it of the resources needed to perform effectively and/or resist efforts at industry capture.</p>

<p><b>Nature of statutory authority</b></p>	<p><b>Broad statutory language that provides the agency with some discretion on the development of rate methods</b></p> <p>Examples: Maryland HSCRC, Rochester RAHC</p> <p>Agencies with significant discretion and flexibility to develop and modify key rate methods may be better able to avoid regulatory failure (inability to adapt to a changing health care market and delivery system).<sup>b</sup></p>	<p><b>Highly prescriptive authority that embeds detailed rate-setting methods in statutes</b></p> <p>Example: New York Prospective Hospital Rate Methodology (NYPHRM)</p> <p>Rate systems that include detailed rate-setting methods in statutes have reduced ability to respond to changes and innovations in care delivery. Needed modifications to rate methods require the statutes to be revised periodically, which invites unfriendly amendments by interested parties. Frequent statutory revisions that are subject to political manipulations can produce rate systems that favor politically powerful entities and, in most cases, add to the complexity and unintelligibility of the rate system.</p>
<p><b>Transparency and agency autonomy</b></p>	<p><b>Strict adherence to a state’s Administrative Procedures Act (APA)</b></p> <p>The APA can add to the transparency of agency operations, reduce the potential for conflicts of interest, and help the agency maintain needed distance from industry attempts to influence its decisions. Strict adherence to the requirements of the APA can ensure appropriate balance between adequate and transparent communication with the regulated industry while preserving sufficient regulatory distance to allow for independent decision-making by agency staff and minimize the corrosive effects of cognitive capture.</p>	<p><b>Minimal or loose adherence to a state’s APA</b></p> <p>Agencies with no or only loose adherence to the APA can create circumstances where representatives of the regulated industry have repeated access to agency personnel and leadership and frequently engage in private communications/ meetings. The absence of strict requirements on industry/agency communications can result in excessive agency exposure to industry lobbying and undermine the due process of the agency.</p>

<p><b>Development of sources of diverse and independent expertise</b></p>	<p><b>Cultivation and use of independent expertise to supplement agency decision-making</b></p> <p>In the volume <i>Preventing Regulatory Capture</i>,<sup>13</sup> several essays emphasize opportunities for reducing the risk of capture by diversifying the sources of expertise in regulatory decision-making. These essays point to the importance of engaging with a diversity of interests and experts, beyond the regulated industry itself. Several mention the potential value of independent academic advisory boards or individual academic experts to review and comment on agency data and methodologies. Another strategy to provide a counterweight to the influence of regulated interests is to promote consumer empowerment through the appointment of an official public advocate.</p>	<p><b>Exclusive reliance on regulatory staff and agency leadership</b></p> <p>Exclusive reliance on the expertise of agency staff, who may be at a knowledge/expertise disadvantage relative to representatives of the regulated industry, and agency leaders, who themselves may be managers and board members of regulated entities, can create a skewed and insulated regulatory perspective that fails to consider regulatory decisions in the context of how they impact the broader public at large (which should be a key priority of any regulatory agency).</p>
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<sup>a</sup> Maryland's statute (which was originally drafted by the Maryland Hospital Association) authorized the appointment of no more than three hospital industry representatives (of a total of seven commissioner slots) to the HSCRC.

<sup>b</sup> The development of a flexible statute that only articulates key goals and policy priorities and does not specify the exact rate methods gives an agency flexibility to devise and adopt rate methods to meet these goals. However, this type of regulatory discretion also can provide a captured agency with significant flexibility to meet the needs and priorities of the regulated industry. Thus, while increasing the independence and autonomy of a regulated agency does not necessarily increase the likelihood of capture, policymakers need to be aware that granting too much discretion carries such a risk. See Hiriart Y, Martimort D. *How Much Discretion for Risk Regulation?* Working paper, October 2009. [http://idei.fr/doc/by/martimort/how\\_much\\_discretion\\_oct09.pdf](http://idei.fr/doc/by/martimort/how_much_discretion_oct09.pdf).

Sources: Review of the literature on regulatory capture and failure and the author's experience on the staff of the Maryland HSCRC.

Although the use of structural features of regulation as discussed in Exhibit 1 can help reduce the risk of capture and failure, a high level of professionalism, strong independent leadership, and an emphasis on civic duty are also important resources for successful regulatory agencies.<sup>41</sup>

## A “DOOMSDAY MACHINE”

Related to the issue of accountability and system performance is a phenomenon in Maryland that diluted the industry’s attempts at regulatory capture and galvanized support for rate setting from all parties, including the regulated industry. The terms of the original Medicare waiver and its financial performance test created a sort of “doomsday machine” (as portrayed in the film *Dr. Strangelove*) in which all parties stood to suffer highly negative consequences should the rate system fail to meet its cost containment goals.

When the system was first established, Medicare’s payment levels to Maryland hospitals in 1977 (the year the waiver was negotiated) were about 30% above the national average. To the state’s considerable benefit, Medicare allowed Maryland to retain this higher level of payment if Medicare payment growth never exceeded this 30% excess level over the life of the system.<sup>42</sup>

By 2014, the value of these excess Medicare payments was estimated to be approximately \$2.0 billion per year, or approximately 14% of total hospital revenue. Should Maryland fail to meet its performance goals under the terms of its Medicare waiver, Maryland hospitals would have been phased into the national Medicare Prospective Payment System, which would reduce total hospital revenues by 14%. The threat of this “doomsday” scenario strongly motivated all parties to do whatever it took to perform at levels sufficient to maintain the waiver and gave the rate-setting agency tremendous leverage in applying rate constraints as necessary to meet its performance goals.<sup>43</sup>

While this situation may not be completely replicable, it does illustrate the power of stringent but attainable cost performance standards established by an external entity (i.e., the federal government) and tied to significant penalties or other consequences for nonperformance. Such a doomsday mechanism can ensure that the regulatory agency remains vigilant in meeting its performance standards and that the regulated industry’s aspirations to capture the regulator are moderated.

## LESSONS FOR FUTURE RATE-SETTING SYSTEMS

The demise of state-based rate setting has not been attributed to regulatory failure or capture, but rather to a loss of interest group support due to political change, a partial collision of rate setting with managed care, and the reduced effectiveness and the inability of these systems to meet their original policy goals – particularly cost containment. This reduced effectiveness, along with the perception that the rate-setting process had become unintelligible and subject to insider manipulation, led to the erosion of support from politicians, insurers, and the business community. The emergence of managed care as a new and effective “pro-market” cost control mechanism and changes in the political leadership

of these states (to parties favoring market-based solutions over regulatory solutions) led directly to the repeal of rate-setting authority in these states in the early 1990s.<sup>44</sup>

In the late 1990s, Harvard T.H. Chan School of Public Health's John McDonough rejected the argument that capture was the primary reason for the demise of three of the four state-based systems. Instead, he concluded that "these regulatory systems benefited consumers more than they benefited the regulated hospitals" and "only in New Jersey could the capture thesis be validated, and then only in the period between 1987 and 1992. The notion that elected and public officials play second fiddle to the agendas of interest groups is flatly rejected by the evidence."<sup>45</sup>

Many of McDonough's observations about the occurrence of capture in the context of state hospital payment systems mirror the conclusions of a comprehensive review of the literature on regulatory capture: (1) capture is often a misdiagnosis that is frequently motivated by political ideology and not backed up by empirical evidence; (2) capture is not binary: while there are examples of extreme capture, it is rarely pervasive or absolute, but instead exists in varying degrees;<sup>46,47</sup> (3) in a world where capture varies, some regulatory systems and agencies have done a better job than others at resisting it; and (4) a number of structural features of regulation can help insulate an agency from an industry's attempts at regulatory capture (Figure 1).<sup>48</sup>

In sum, debilitating levels of regulatory capture and regulatory failure are not inevitable. Both can be largely prevented and, if they occur, minimized. Less complex and interventionist regulatory systems, such as establishing price caps on out-of-network services or developing flexible hospital global budgets, have the benefit of minimizing the danger of failure and capture, while at the same time directly mitigating the pricing market power that most hospitals now possess.<sup>49</sup>

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## NOTES

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- <sup>18</sup> Letter by Richard Olney to Charles Perkins, president, Chicago, Burlington & Quincy Railroad, December 28, 1892. The first federal regulatory agency, the ICC, was set up to regulate railroad freight rates in the 1880s. Soon after, Richard Olney, a prominent railroad lawyer, came to Washington to serve as attorney general. Olney was asked if he would help kill off the hated ICC. His reply was a premonition of the dynamic that was to follow with the ICC: “The Commission is, or can be made, of great use to the railroads. It satisfies the popular clamor for a government supervision of the railroads, at the same time that it that supervision is almost entirely nominal. Further, the older such a Commission gets to be, the more inclined it will be found to take the business and railroad view of things. The part of the wisdom is not to destroy the Commission, but to utilize it.”
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