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# Identifying the causes of rising health care costs

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Lessons for Colorado from other States

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## Colorado’s rising health care costs

Rising health care costs are presenting serious challenges for Coloradans. Between 2000 and 2010 the average yearly premium for a family with private insurance skyrocketed from \$6,797 to \$13,393, a 97 percent increase.<sup>1</sup> The majority of Americans already report forgoing or delaying care because of costs.<sup>2</sup> Colorado policymakers have taken some steps to address the problem, but their efforts are hindered by a lack of information. Specifically, policymakers have not collected the necessary data to make informed judgments about the various factors in the health care system that could be contributing to rising health costs.

Colorado policymakers have taken some actions to contain health care costs with delivery and payment reform initiatives. The Accountable Care Collaborative (ACC) program aims to increase primary care use and case management to contain costs in the Medicaid program. A payment reform initiative within the ACC program will test different forms of provider payments and incentives to try and lower costs. The Center for Improving Value in Health Care (CIVHC) is working on payment reform models in the private marketplace. The All Payer Claims Database (APCD), overseen by CIVHC, will increase the amount of health care data available within the state to help identify trends that can lower costs. Still, Colorado can do more. Colorado can start by learning from four states that have taken cost containment steps. Some states research what is driving costs across the entire health care system. Other states use regulatory policies to curb costs. All four states show it is important to examine the whole health care market in cost containment discussions. Although it is too early to say how all of these state policies will affect cost, Colorado can learn lessons from them as it continues to examine health care costs.

## Pricing variation—a problem

Recent research suggests vast pricing variation exists across payers and providers and may contribute to the growth in health care costs.<sup>3</sup> Variation likely exists in Colorado, but the state lacks a cost and price informational baseline to use in health care reform decisions. Colorado’s APCD will illuminate variation in amounts paid by different sources. However, understanding why variation exists and what factors dictate the negotiated rates between payers and providers is crucial if Colorado is going to curb health care cost growth.

### State policy examples offer guidance

Other states use a range of strategies to analyze market forces and regulate the market. This paper examines cost containment policy examples from Massachusetts, Alaska, Vermont, and Maryland. The state examples fall into two categories: efforts to identify cost drivers and efforts to regulate cost growth. Each

State	Cost Containment Strategy
Massachusetts	<ul style="list-style-type: none"><li>• Attorney general review of health plans and providers</li><li>• Cost containment legislation</li></ul>
Alaska	<ul style="list-style-type: none"><li>• Private actuarial analysis of health plans and providers</li></ul>
Vermont	<ul style="list-style-type: none"><li>• Hospital budget review: increases limited to 3.75 percent net patient revenue</li></ul>
Maryland	<ul style="list-style-type: none"><li>• Hospital rate setting</li></ul>

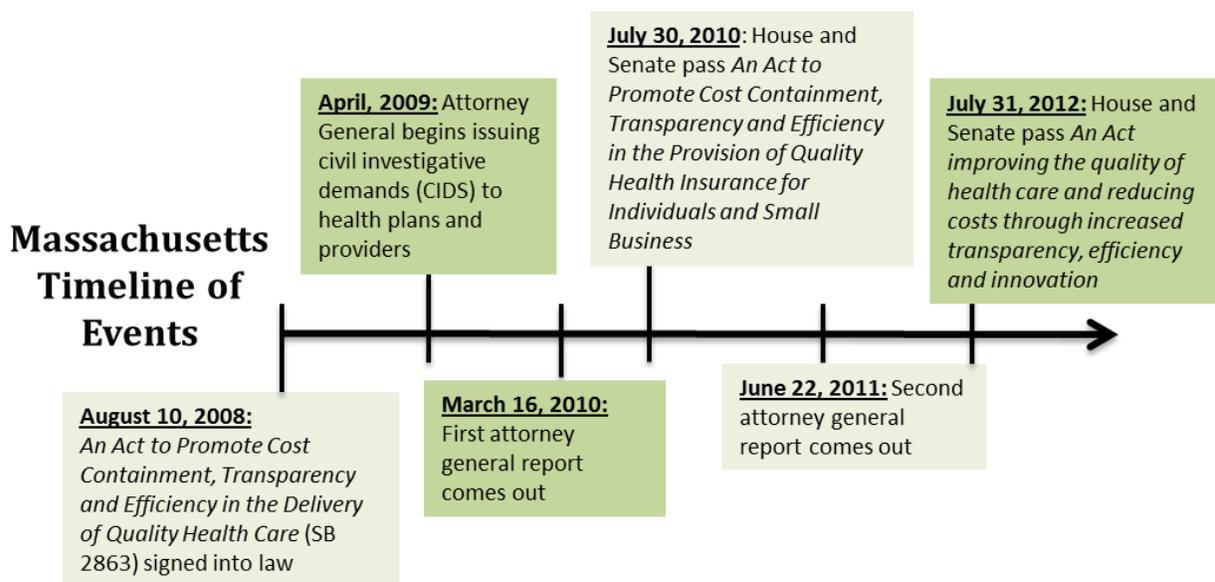
state has taken a unique path, but all show the importance of examining market forces in cost discussions. Colorado must start a conversation about the impact of system-wide health care market forces as we seek to stop the unsustainable growth in health care costs.

**Massachusetts: clear information creates change**

In 2008, Massachusetts passed legislation that enabled the state to examine proprietary cost information from health plans and payers.<sup>4</sup> The bill aimed to increase health care transparency and contain costs. Specifically, it appointed the Department of Health Care Finance and Policy (DHCFP) to conduct annual public hearings concerning public and private payers’ and providers’ cost trends and factors contributing to cost growth.<sup>5</sup> The bill also tasked the state’s attorney general to intervene in the hearings and granted the attorney general power to

require any provider or payer [to] produce documents and testimony under oath related to health care costs and cost trends or documents that the attorney general deems necessary to evaluate factors that contribute to cost growth within the commonwealth’s health care system and to the relationship between provider costs and payer premium rates.<sup>6</sup>

The law also requires the attorney general to create an annual report based on this information.



Massachusetts Attorney General Martha Coakley issued civil investigative demands (CIDS) to health plans and providers starting in April of 2009. The attorney general also conducted interviews with providers, advocates, and other health experts, and contracted with private consultants with extensive knowledge of the Massachusetts health care market. Through this process, the attorney general identified specific factors that drive health care costs in Massachusetts.

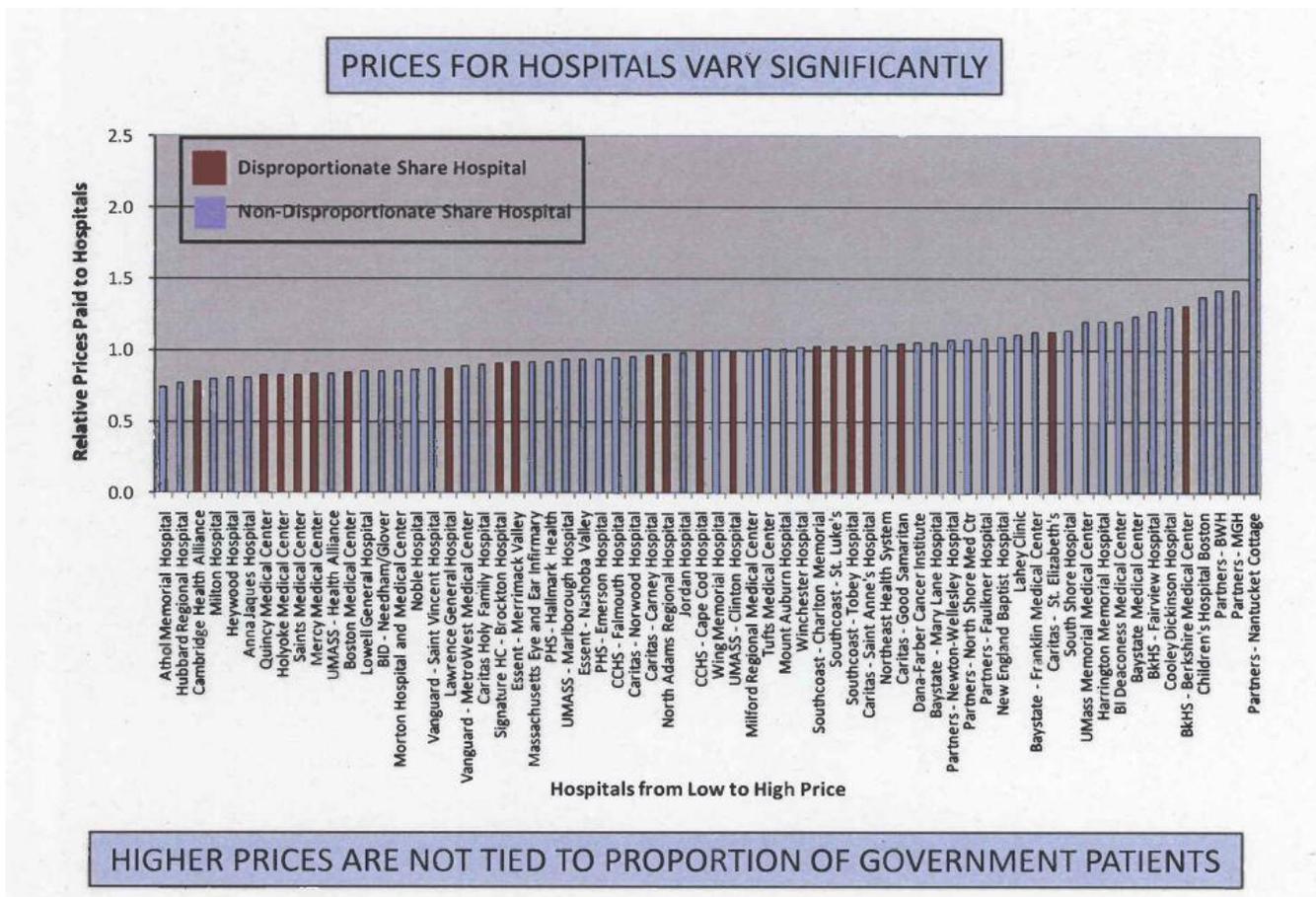
**The Massachusetts annual report findings**

The 2010 and 2011 reports outline several important findings. First, prices paid by health plans to providers vary significantly even in the same geographic area among providers offering

similar services. After identifying this variation, the attorney general looked at whether variation can be attributed to measurable value. The attorney general found:

- Cost and quality do not correlate.
- Price variation is not adequately explained by patient acuity or complexity of service; teaching or research status; percent of Medicare and Medicaid patients served; or by the differences in hospital costs of providing similar services at similar facilities.
- Price increases, not increased utilization, account for the majority of health care cost increases in Massachusetts.
- Price variation is linked to the respective market leverage of insurers and providers—with name recognition adding increased leverage.

These four findings serve as a baseline from which the attorney general was able to explore other health care market trends and payment reform efforts, including patient volume and global budget trends.



From: Examination of Health Care Cost Trends and Cost Drivers, 2010

The attorney general found that variation in pricing impacts the increase of health care costs in the state as a whole. Providers who charge more generate greater revenue. Higher revenue is used to invest in cost structure, such as newer buildings and updated technologies, whereas providers who charge less are unable to make similar investments. Newer facilities in turn attract

larger numbers of patients. The attorney general found the market is shifting towards higher-cost providers, while more efficient providers, delivering the same services at a lower cost, are losing patients. As patient-volume shifts towards higher priced providers, pricing disparities are reinforced and perpetuated, creating a higher cost health care system overall.

Additionally, globally budgeted providers—where health insurers give providers a maximum budget cap to cover all the care of a patient regardless of where the patient gets care—do not have consistently lower total medical expenses (TME) than providers paid in a fee for service (FFS) model. The attorney general found that because global contract rates vary from provider to provider due to negotiations between the insurer and provider, historic pricing disparities are reinforced in these negotiations. For example, within the same insurance network, two providers received different global payments; one provider received a \$428 health status adjusted per member per month (PMPM) amount compared to another provider who got \$276 PMPM. Disparities in payment amounts leave lower-paid providers with a higher likelihood of ending the year with a deficit rather than a surplus. In Massachusetts, one provider ran a deficit while spending an average of \$288 PMPM. The same year, other providers spent more than \$288 PMPM but did not have to pay a deficit because original global budget contracts were set much higher due to negotiations. The attorney general concludes the state needs to better understand and address historic pricing disparities before moving forward with payment reform.

### **Regulatory action**

A 2010 bill, a direct result of the 2010 cost driver report,<sup>7</sup> required DHCFP to collect and publically report information from health care payers regarding the prices paid to providers, among other cost related information.<sup>8</sup> The attorney general's report showed the negotiated rating system leads to vast pricing variation that increases the cost of health care. Increasing pricing transparency was a legislative solution.

In July 2012 Massachusetts passed another bill aimed at health care cost containment. The attorney general's office stayed highly involved as the new legislation was drafted to ensure more transparency around prices and more oversight of providers and their impact on the market.<sup>9</sup> These goals are addressed in the new law. At the consumer level, the law requires insurers to quote prices to consumers if they ask and creates a new price website for consumers. At the provider level, there is a new process providers must go through to register with the state; providers must also “report regularly on financial performance, market share, cost trends, and quality measures.”<sup>10</sup> There are also plans to create a system to track price variation across providers over time. At the state level, DHCFP has been dissolved in lieu of the Health Policy Commission and the Center for Health Information and Analysis,<sup>11</sup> which is designed to create a more independent health care oversight system. The commission is a policy and regulatory board that oversees the transition to a new payment system. Additionally, if providers or provider organizations seek to grow, the commission can order a “Market and Cost Impact Review.” The review will look at how the provider organization functions in the market place. If providers or provider organizations have a dominant market share or higher prices, the commission can refer them to the attorney general, who can investigate them. The Center for Health Information and Analysis collects and publishes health care data.

## **Lessons from Massachusetts**

The attorney general concludes that many of the frequently cited explanations for higher costs—such as cost shifting due to Medicaid and Medicare rate, patient acuity, and teaching status—do not adequately explain price variation. Instead, market issues have a large impact, demonstrating the importance of seeking out the root causes behind a high cost health system. Colorado should consider what role frequently cited factors actually play in driving health care costs in our state and what opportunities exist to better understand other potential cost drivers.

The Massachusetts' experience also highlights the ability of state policymakers to craft specific solutions that target health care cost drivers at the state level once accurate information about the sources of cost growth is available.

## **Alaska: private review of cost drivers**

In 2008, Governor Sarah Palin chartered the Alaska Health Care Commission to develop a statewide plan "to address the quality, accessibility and availability of health care for all citizens of the state."<sup>12</sup> The commission is required to submit a yearly report to the state legislature in January. The first report, issued in 2009, identified the reduction of health costs to below national averages as a central goal.<sup>13</sup> The report named utilization and pricing as two main cost drivers, explaining that between 1990 and 2005, utilization accounted for 1.2 percent of the average annual health care spending increase while general inflation accounted for 2.4 percent. However, as the total annual rate of health care costs grew at an average yearly rate of 8.9 percent, 5.3 percent was unaccounted for.<sup>14</sup> The report listed a number of factors as potential components behind the 5.3 percent figure including: higher cost of living, geography, economies of scale, high workers' compensation, and the seasonal nature of work.

The commission identified key areas to explore: understanding the difference between billed charges and actual provider reimbursement levels and the process of cost shifting.<sup>15</sup> They concluded, "a more comprehensive analysis of fees paid by all major payers and programs should be conducted. An analysis of variations in fees paid within Alaska as well as comparisons to other states should be included."<sup>16</sup>

Research needs led to a contract with Milliman, a private actuarial firm, to conduct a series of three reports, all released in 2011.

- *Physician Payment Rates in Alaska and Comparison States*
- *Facility Payment Rates in Alaska and Comparison States*
- *Drivers of Health Care Cost in Alaska and Comparison States*

The first two reports examine what was happening in Alaska, while the third report synthesizes the information and explains why.

### *Physician Payment Rates in Alaska and Comparison States*

The first report compared Alaska's physician payment rates with Washington, Oregon, Idaho, Wyoming, and North Dakota. Milliman's analysis found physician reimbursement rates in Alaska were approximately 59 percent higher than the average of comparison states. (See chart below.)

### Physician Reimbursement Levels by State and Payer

	AK	ID	ND	OR <sup>(1)</sup>	WA <sup>(1)</sup>	WY
Medicare <sup>(1)</sup>	127%	96%	98%	100%	105%	101%
Tricare <sup>(1)</sup>	182%	97%	97%	101%	104%	101%
VA	215%	96%	98%	100%	105%	101%
Medicaid	174%	99%	134%	87%	68%	113%
Workers' Compensation	190%	108%	98%	107%	86%	N/A
Comm Allowed - Mean	169%	96%	96%	112%	92%	105%
Comm Allowed - Median	181%	94%	97%	113%	88%	107%
Comm Allowed - 80th Percentile	176%	98%	89%	110%	92%	111%
Billed - Mean	142%	90%	96%	113%	107%	95%
Billed - Median	147%	89%	98%	114%	105%	93%
Billed - 80th Percentile	135%	93%	93%	112%	104%	98%
All Payers <sup>(2)</sup>	160%	97%	105%	102%	91%	103%

All values are relative to the average for the five comparison states (excluding AK) for each payer category

From: *Physician Payment Rates in Alaska and Comparison States*, showing the 59 percent difference

Milliman studied Alaska's private insurance market by summarizing the mean, median, and 80<sup>th</sup> percentile of billed charges from a database<sup>17</sup> of health care claims. Due to the lack of more detailed data from the private market, Milliman could only generalize billed charges. The disparity of specificity between Massachusetts' and Alaska's findings highlights the need to extract detailed data from the private market if a state wants a clear understanding of what is occurring within its health system.

#### *Facility Payment Rates in Alaska and Comparison States*

This report compared Alaska's commercial and Medicare hospital payment rates with Washington, Oregon, Idaho, Wyoming, North Dakota and Hawaii. The findings indicated Alaska has higher commercial and Medicare hospital payment levels. Compared with the average of the six other states, Alaska's commercial hospital payment level was 37 percent higher while the Medicare hospital payment level was 36 percent higher.

#### *Drivers of Health Care Cost in Alaska and Comparison States*

The final report examined what was driving costs and identified state trends.

- Commercial premiums are approximately 30 percent higher than the comparison states' average.
- Alaska's total non-federal hospital operating cost is 138 percent higher than comparison states.<sup>18</sup>
- Urban Alaskan hospitals have higher than average profit margin that can be largely explained by the existence of two for-profit hospitals, Alaska Regional Hospital and Mat-Su Medical Center. For the state as a whole, the average margin for non-federal hospitals is 13.8 percent, 6.9 percent higher than the national average.

Physicians have large power in negotiating the fees they are paid by commercial payers due to the relative lack of competition among providers. High reimbursement levels result "in higher profit for private sector facilities in Alaska, particularly in the urban areas, and higher compensation for physician services relative to the overall cost of living."<sup>19</sup> Milliman also notes

that some of Alaska’s higher provider reimbursement rates are attributable to the higher costs incurred by Alaskan providers compared to other states.

The biggest finding from the reports is that physicians have significant pricing power within the state, according to the executive director of the Alaska Health Care Commission.<sup>20</sup> Additionally, she notes that although no legislative action has been taken in Alaska, the Alaska reports exemplify how transparency can shift the health care discussion. Prior to publication, providers were aware of higher than average costs in Alaska, but not aware of the magnitude. After publication, a new dialogue has begun among private insurers, providers, and the Commission about health care costs.<sup>21</sup>

**Lessons from Alaska**

Colorado relies extensively on private, public and community partnerships in its policy making process. The efforts in Alaska demonstrate that clear data can start a dialogue among different stakeholders and get new parties interested in tackling the high cost of health care. Colorado’s All Payer Claims Database will show utilization and spending patterns. We also need to push deeper and ask *why* the patterns exist, focusing on the root causes of health care cost increases.

**Comparing Massachusetts and Alaska cost driver studies**

The cost driver reports for Alaska and Massachusetts draw some similar conclusions in spite of the different methodologies used and the vast differences between the two states including: the predominance of public versus private coverage, population density, and the political landscapes.

<b>Findings regarding cost growth from two states</b>		
<b>Factor</b>	<b>Massachusetts</b>	<b>Alaska</b>
<b>Negotiating Power</b>	Price variation arises from negotiations between providers and payers based on market leverage.	Higher prices are due to high physician negotiating power.
<b>Hospital Patterns</b>	Higher-priced hospitals are gaining market share at the expense of lower-priced hospitals, resulting in a higher cost health system overall.	Urban hospitals have higher than average margins of profit that can be largely explained by two for-profit hospitals.
<b>Utilization</b>	Not a major factor in cost increases. Price increases have caused most cost increases.	Not a major driver behind higher premium rates.

Both states conclude negotiations between providers and payers lead to higher prices, that hospitals patterns impact cost, and that increased utilization is not a major cost driver.

### **Vermont: hospital budget review**

Vermont's hospital regulation dates back to 1983, with state law 9456. *Budget review*. The law required annual government reviews of hospital budgets and public transparency measures. The public was given an opportunity to comment at public hospital budget meetings and public noticing prior to meetings was required.<sup>22</sup> Although a report notes Vermont's Legislative Council and Joint Fiscal Office cited the hospital budgeting law as being frequently ignored<sup>23</sup> it remained active until the establishment of Vermont's Green Mountain Care Board (GMCB) in May 2011. GMCB assumed responsibility for hospital budget review under new policy guidelines that limit hospital increases to 3.75 percent of net patient revenue, with some exceptions. Net patient revenue is "how much a hospital makes from all its patient services combined."<sup>24</sup> The 3.75 percent cap is the major change from the old budget review system. Hospital reviews operate in conjunction with health insurance rate review and certificate of need (CON) review, all aimed at containing Vermont's health care costs, and all undertaken by GMCB.

Public hearings are still required, and it is up to the board's discretion to require hospitals to "provide testimony and respond to questions raised by the Board or the public."<sup>25</sup> GMCB has the power to change hospital rates or prices or change the net revenue and/or expenditure levels of future budgets if it is determined the hospital has substantially varied from its approved annual budget. GMCB can also increase rates and pricing if a hospital experiences a deficit from less than projected revenue.

GMCB's first year of hospital budget regulation with new increase limits began with a public hearing on August 14, 2012. Vermont's 14 hospitals asked for an average of 7.1 percent increases for fiscal year 2012-2013. GMCB approved budgets for twelve of the fourteen hospitals. Two were required to resubmit budgets. In fiscal year 2013 net patient revenue will increase by 5.1 percent after factoring out some allowed exemptions, a 2 percent reduction from what was requested.

### **Lessons from Vermont**

An important aspect for Colorado to take note of is the requirement that hospitals disclose financial information such as "costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of service, and wage and salary data." Financial transparency increases the ability of policymakers to both understand what is happening in state hospitals and regulate the health care market as needed.

### **Maryland's hospital rate-setting system**

A 1971 law passed by the Maryland legislature created a hospital rate-setting system overseen by the Health Services Cost Review Commission (HSCRC). Rate setting is a process in which rates, the amount paid for specific health services rendered at a hospital, are set at the same amount for all payers. The 1971 law originated due to rapidly rising health costs after the creation of Medicare and Medicaid and a fear of hospital insolvency due to increasing levels of uncompensated care.<sup>26</sup> The legislature, strongly supported by the Maryland Hospital Association, came together around three key goals, to increase "access, solvency and equity."<sup>27</sup> The law keeps

HSCRC financially and politically independent. A hospital user fee funds the HSCRC and the commission is an independent body. HSCRC, a commission of seven voluntary members appointed by the governor, only three of which can have provider affiliations, began setting rates for all nongovernmental payers in 1974. In 1977, Maryland was granted a waiver by the federal government that enabled the state to set rates for Medicaid and Medicare. Maryland must continue to meet certain federal criteria to maintain the waiver—the key piece that allows the state to keep its rate-setting system in place. In addition, Maryland’s growth in payment per admission must stay below national growth levels. The most recent test shows Maryland’s growth rate from 1981-2011 was 343 percent compared to the national increase of 362 percent.<sup>28</sup> If the nation’s cost growth had increased at Maryland’s rate from 1976 to 2007, the savings would have been over \$1.8 trillion dollars.<sup>29</sup> Furthermore, the rating system has kept “the mark-up, i.e., the difference between hospital costs and charges, in Maryland hospitals the lowest in the nation at 27 percent, compared to the average mark-up of 212 percent for hospitals nationally, according to the most recent data from the American Hospital Association (AHA).”<sup>30</sup>

### **Lessons from Maryland**

In 1971, Maryland’s legislators did not trust the market to self-regulate the cost of health care and thus created a rate-setting system that has continually kept the state’s hospital costs below national averages. The Commonwealth Fund, a private health foundation, re-examined rate setting in a 2009 issue brief that argues for the success of the Maryland system.<sup>31</sup> In 1974, charges were only 5 percent higher than costs nationally, and 9 percent higher in Maryland. By 2007, charges were 182 percent higher than cost nationally but only 21 percent higher in Maryland. In a 2011 paper, Uwe Reinhardt, a Princeton economics professor, argues that the United States should implement a multi-payer, all-payer system (where different payers pay the same rates), like the system in Maryland, to control costs.<sup>32</sup> Hospital rate setting was popular in the 1970s and was implemented by a number of states, including Colorado. Like Colorado, other states stopped rate setting within a few years. Although rate setting is often considered an outdated and unfeasible idea, Maryland has done a better job at containing hospital costs than other states.

### **Conclusion**

The experiences of other states offer lessons for Colorado. As Colorado embarks on many payment and delivery system reform pilot programs, shifts its Medicaid population into Accountable Care Collaboratives, and grapples with strategies to bring down costs across the state, it is important to consider what information is missing from policy discussions. Colorado lacks a clear understanding of how its health care market functions and what drives costs. The All Payer Claims Data Base will offer significant opportunities to compare paid amounts among those payers that choose to participate. However, policymakers must understand what drives costs before Colorado can set policies to control them. Colorado has the opportunity to expand on the knowledge gained across the country and start a meaningful conversation about the rising cost of health care. With a state-specific strategy, Colorado can design meaningful solutions to the escalating cost of health care.

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<sup>1</sup> DORA Staff. "Annual Report of the Commissioner of Insurance to the Colorado General Assembly on 2011 Health Insurance Costs." Page 19 . Colorado Department of Regulatory Agencies, 16 Feb. 2011. Web. <<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content->

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Type&blobheadervalue1=inline%3B+filename%3D%22Health+Cost+Report+2011+(1.2+MB).pdf  
%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=12  
51814995017&ssbinary=true>.

- <sup>2</sup> "Kaiser Public Opinion, Health Security Watch." Kaiser Family Foundation, June 2012. Web.  
<<http://www.kff.org/healthpollreport/CurrentEdition/security/upload/8322.pdf>>.
- <sup>3</sup> Ginsburg, Paul B. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." *HSC Research Brief No. 16*. N.p., Nov. 2010. Web. 13 Mar. 2013  
<<http://www.hschange.com/CONTENT/1162/>>.
- Reinhardt, Uwe E. "Equalizing Payments for Medical Care." *New York Times*. N.p., 11 Nov. 2011. Web.  
13 Mar. 2013. <<http://economix.blogs.nytimes.com/2011/11/11/equalizing-payments-for-medical-care/>>.
- Devers, Kelly J., Lawrence P. Casalino, and Liza S. Brewster. "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed?" Health Services Research, Feb. 2003. Web.  
<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360893/>>.
- Brill, Steven. "Bitter Pill: Why Medical Bills Are Killing Us." *Time*. Time, 4 Mar. 2013. Web. 13 Mar. 2013.
- <sup>4</sup> Massachusetts. Senate. AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE. Senate, No. 2863. July 31, 2008. Web. <http://www.mass.gov/legis/bills/senate/185/st02pdf/st02863.pdf>
- <sup>5</sup> Massachusetts. Senate. AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY ANDEFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE. Senate, No. 2863. July 31, 2008. Web. <http://www.mass.gov/legis/bills/senate/185/st02pdf/st02863.pdf>
- <sup>6</sup> Massachusetts. Senate. AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY ANDEFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE. Senate, No. 2863. July 31, 2008. Web. <http://www.mass.gov/legis/bills/senate/185/st02pdf/st02863.pdf>
- <sup>7</sup> Johnson, Lois. Phone interview. 30 Aug. 2012.
- <sup>8</sup> Note, the Department of Health Care Finance and Policy has since been dissolved.  
Massachusetts. Acts 2010, CHAPTER 288, AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE PROVISION OF QUALITY HEALTH INSURANCE FOR INDIVIDUALS AND SMALL BUSINESSES.  
<http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>
- <sup>9</sup> Johnson, Lois. Phone interview. 30 Aug. 2012.
- <sup>10</sup> "The Next Phase of Massachusetts Health Care Reform." *Legislative Summary*. Massachusetts, n.d. Web.<<http://www.mass.gov/governor/agenda/healthcare/cost-containment/health-care-cost-containment-legislative-summary.pdf>>.
- <sup>11</sup> *The Abbreviated Version: Massachusetts S.B. 2400, "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation."*. Ed. Doug Perednia, M.D. Road to Health, n.d. Web. <<http://roadtohellth.com/wp-content/uploads/2012/08/Abbreviated-Massachusetts-SB-2400.pdf>>.
- <sup>12</sup> *Transforming Health Care in Alaska 2009, Report/2010 – 2014 Strategic Plan*. Alaska Health Care Commission, Jan. 2010. Page 4. Web. <<http://dhss.alaska.gov/ahcc/Documents/docs/report.pdf>>.
- <sup>13</sup> *Transforming Health Care in Alaska 2009, Report/2010 – 2014 Strategic Plan*. Alaska Health Care Commission, Jan. 2010. Page 10. Web.  
<<http://dhss.alaska.gov/ahcc/Documents/docs/report.pdf>>.
- <sup>14</sup> *Transforming Health Care in Alaska 2009, Report/2010 – 2014 Strategic Plan*. Alaska Health Care Commission, Jan. 2010. Page 17. Web.  
<<http://dhss.alaska.gov/ahcc/Documents/docs/report.pdf>>.
- <sup>15</sup> *Transforming Health Care in Alaska 2009, Report/2010 – 2014 Strategic Plan*. Alaska Health Care Commission, Jan. 2010. Page 19. Web.  
<<http://dhss.alaska.gov/ahcc/Documents/docs/report.pdf>>.
- <sup>16</sup> *Transforming Health Care in Alaska 2009, Report/2010 – 2014 Strategic Plan*. Alaska Health Care

- 
- Commission, Jan. 2010. Page 19. Web.  
<<http://dhss.alaska.gov/ahcc/Documents/docs/report.pdf>>.
- <sup>17</sup> Data Source: 2009 Thomson Reuters MarketScan
- <sup>18</sup> *Drivers of Health Care Costs in Alaska and Comparison States*. Rep. Milliman, Inc., 29 Nov. 2011. Web. Page 14. <[http://dhss.alaska.gov/ahcc/Documents/docs/drivers\\_healthcare\\_costs.pdf](http://dhss.alaska.gov/ahcc/Documents/docs/drivers_healthcare_costs.pdf)>.
- <sup>19</sup> *Drivers of Health Care Costs in Alaska and Comparison States*. Rep. Milliman, Inc., 29 Nov. 2011. Web. Page 1. <[http://dhss.alaska.gov/ahcc/Documents/docs/drivers\\_healthcare\\_costs.pdf](http://dhss.alaska.gov/ahcc/Documents/docs/drivers_healthcare_costs.pdf)>.
- <sup>20</sup> Erickson, Deborah. Phone interview. 3 Dec. 2012
- <sup>21</sup> Erickson, Deborah. Phone interview. 3 Dec. 2012
- <sup>22</sup> The Vermont Statutes Online, Title 18: Health.  
<http://www.leg.state.vt.us/statutes/chapters.cfm?Title=18>
- <sup>23</sup> H M Leichter, State model: Vermont. Health care reform in Vermont: a work in progress, *Health Affairs*, 12, no.2 (1993):71-81. Page 73. <http://content.healthaffairs.org/content/12/2/71.citati>
- <sup>24</sup> Green Mountain Care Board. *Introduction to Vermont's Hospital Budget Review*. N.p., n.d. Web. <<http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB%20Hospital%20Budget%20Review.pdf>>.
- <sup>25</sup> Green Mountain Care Board Rule 3.000: Hospital Budget Review. Page 4.  
<http://gmcboard.vermont.gov/sites/gmcboard/files/HBDraftRule071312.pdf>
- <sup>26</sup> Cohen, Ph. D, Harold A. "Maryland's All-Payor Hospital Payment System." Maryland Health Services Cost Review Commission, 2011. Web. Page 2.  
<[http://www.hsrc.state.md.us/documents/HSRC\\_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf](http://www.hsrc.state.md.us/documents/HSRC_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf)>.
- <sup>27</sup> Cohen, Ph. D, Harold A. "Maryland's All-Payor Hospital Payment System." Maryland Health Services Cost Review Commission, 2011. Web. Page 3.  
<[http://www.hsrc.state.md.us/documents/HSRC\\_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf](http://www.hsrc.state.md.us/documents/HSRC_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf)>.
- <sup>28</sup> *REPORT TO THE GOVERNOR FISCAL YEAR 2012 MARTIN O'MALLEY GOVERNOR. STATE OF MARYLAND HEALTH SERVICES COST REVIEW COMMISSION*, June 2012. Web. Page 7.  
<<http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/016000/016106/unrestricted/20121942e.pdf>>.
- <sup>29</sup> Robert Murray, Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience. Page 1396. *Health Affairs*, 28, no.5 (2009):1395-1405  
<http://content.healthaffairs.org/content/28/5/1395.full.html>
- <sup>30</sup> Robert Murray, Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience. Page 1400. *Health Affairs*, 28, no.5 (2009):1395-1405  
<http://content.healthaffairs.org/content/28/5/1395.full.html>
- <sup>31</sup> G. Atkinson, State Hospital Rate-Setting Revisited. Page 3. The Commonwealth Fund, October 2009.  
<http://www.commonwealthfund.org/Publications/Issue-Briefs/2009/Oct/State-Hospital-Rate-Setting-Revisited.aspx#citation>
- <sup>32</sup> Reinhardt, U. (2012), Divide et impera: protecting the growth of health care incomes (COSTS). *Health Econ.*, 21: 41–54. doi: 10.1002/hecl.1813  
<[http://www.bettmartinezinsurancesolutions.com/uploads/MAYNARD\\_PAPER\\_25TH\\_JAN\\_2012.pdf](http://www.bettmartinezinsurancesolutions.com/uploads/MAYNARD_PAPER_25TH_JAN_2012.pdf)>