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PRICING PRACTICES OF HOSPITALS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

U.S. HOUSE OF REPRESENTATIVES

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PRICING PRACTICES OF HOSPITALS

TUESDAY, JUNE 22, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Amo Houghton (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

FOR IMMEDIATE RELEASE
June 15, 2004
OV–14

CONTACT: (202) 225–7601

Houghton Announces First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals

Congressman Amo Houghton (R–NY), Chairman, Subcommittee on Oversight of the Committee on Ways and Means, today announced that the Subcommittee will hold the first in a series of hearings on tax exemption issues. This hearing will examine pricing practices of tax-exempt and other hospitals. **The hearing will take place on Tuesday, June 22, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from a variety of health care groups and outside experts.

BACKGROUND:

Overall there are more than 300,000 reporting tax-exempt 501(c)(3) entities. Hospitals represented a small proportion (1.9 percent) of total reporting charitable 501(c)(3)s but, in 2001, constituted 41 percent ($337 billion) of total expenditures. Under current law, hospitals are considered tax exempt because they promote the health of a class of persons broad enough to benefit the community as a whole. Such community benefit is deemed to be a charitable purpose. Another approach is to view tax-exemption as a subsidy for the costs that the Federal Government would otherwise incur, such as charity care.

Hospitals bill for all the charges for items and services used by a patient after a hospital stay. Many hospitals increase their charges to shift the costs of treating the indigent onto public and private payors. In 2002, hospital charges exceeded their average costs by 118 percent (Centers for Medicare and Medicaid Services (CMS)). Because they do not have a contract with a hospital, individuals without health insurance are billed full charges. Thus, the uninsured are liable for charges which were inflated to cover the costs of indigent medical care. In addition, taxpayers subsidize the $22 billion in costs of the indigent through $23 billion a year in special Medicare Part A payments and other government subsidies.

Hospital charges are not transparent. So consumers, including the uninsured, do not have access to information on the costs of medical treatment across hospitals. Some advocate empowering consumers with information on hospital costs and quality will increase competition and slow medical cost inflation.

In announcing the hearing, Chairman Houghton stated, "The rising cost of health care is a concern. This is on everyone's mind. So what can we do to help? One thing is to look at ways to make hospital prices more transparent. Anything we are able to do to increase the amount of information available on health care so users can better make up their minds would, to my mind, help reduce costs."

FOCUS OF THE HEARING:

The hearing will examine the current hospital pricing system and focus on the lack of transparency in hospital charges, which hinders consumers from making in-

formed choices about where they get care and the options for increasing information about hospital pricing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "108th Congress" from the menu entitled, "Hearing Archives" (http://waysandmeans.house.gov/Hearings.asp?congress=16). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Tuesday, July 6, 2004. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman HOUGHTON. Good morning, everybody. Thanks for being here today, an important meeting. During our hearing today we will look at nonprofit hospitals and also the larger issues of hospital pricing. I particularly want to thank the members of the panel for being here this morning. As we all know, or most of us know, there are 300,000 501(c)(3) organizations ranging from universities to blood donor organizations. Hospitals make up a significant part of total expenses in this category. As a part of our oversight agenda, it is important that we review topics such as tax-exempt hospital prices, charity care, quality of care, and the services offered by for-profits versus not-for-profits.

Relating to the financial situation by hospitals in my district, just to give you an example, Standard & Poor's has recently reported that New York hospitals still have some of the weakest access to capital in the Nation, attributed in part to the former government-mandated rate regulation. Despite their finances, our local hospitals also provide charity care, and I am sure this is true in many other hospitals in different parts of the country. At Arnot Ogden Medical Center in Elmira, New York in upstate New York, the Community Care Program provides discounts up to 300 percent of the Federal poverty level. Information on the policy is publicly posted.

Another example, F.F. Thompson Hospital in Canandaigua has a sliding fee policy that provides discounts up to 100 percent for persons with wages below 200 percent of the Federal poverty level. Still another example, at Jones Memorial Hospital in Wellsville, a small town in our area, a financial aid counselor will confidentially visit patients who are admitted with no health insurance, to make sure the patient knows that free or discounted care is available for patients in need. One topic we are going to be exploring today is hospital pricing. I have before me what is called a "charge master." This makes for fascinating reading.

[Laughter.]

I thought the Tax Code was complicated, but it is nothing like this. Hospitals seem to be stuck with a broken billing system and no one knows the cost of services in advance. So, people receive bills for services where the charges appear too high for a hospital gown or even an aspirin, and they do not understand that these amounts are not what insurance is going to pay for. People without health insurance individually negotiate payment with hospitals, a process that creates anxiety and a lot of uncertainty. If we could do it all over again, I am sure this is not a system that anyone in his right mind would dream up.

Appearing before us today on the first panel are experts who can describe how we got where we are, and what we might do to change. On the next panel we have distinguished representatives from hospitals, as well as an expert on government pricing, who are able to bring real world experience to bear on this very difficult problem. I welcome you all. Thank you for being here, and I look forward to your testimony. I am now pleased to yield to our ranking Democrat, my distinguished associate, Mr. Pomeroy.

[The opening statement of Chairman Houghton follows:]

Opening Statement of The Honorable Amo Houghton, Chairman, and a Representative in Congress from the State of New York

Good morning. During our hearing today we will look at non-profit hospitals and at the larger issue of hospital pricing. There are many—over 300,000—501(c)(3) organizations ranging from universities to blood donor organizations. Hospitals make up a significant part of total expenses in this category. As a part of our oversight agenda, it is important that we review topics such as tax-exempt hospital prices, charity care, quality of care, and the services offered by for-profits versus not for profits.

I am familiar with the financial situation faced by hospitals in my district. Standard and Poors, the bond rating agency, recently reported that New York hospitals still have some of the weakest access to capital in the nation, attributed in part to the former government-mandated rate regulation. Despite their finances, my local hospitals also provide charity care. For example:

- At Arnot Ogden Medical Center in Elmira the Community Care Program provides discounts up to 300% of the federal poverty level. Information on the policy is publicly posted.
- Similarly, F.F. Thompson Hospital in Canandaigua has a sliding fee policy that provides discounts up to 100% for persons with wages below 200% of the federal poverty level.
- At Jones Memorial Hospital in Wellsville a financial aid counselor will confidentially visit patients that are admitted with no health insurance to make sure the patient knows that free or discounted care is available for patients in need.

One important topic we will explore today is hospital pricing. I have before me what is called a "charge master" for a small hospital. Now I thought the tax code was complicated, but much in these 200 pages does not make sense.

Hospitals seem to be stuck with a broken billing system. No one knows the costs of the services in advance. People receive bills for services where the charges appear too high for a hospital gown or an aspirin. They don't understand that these amounts are not what their insurance will pay. People without health insurance individually negotiate payment with hospitals, a process that creates anxiety and uncertainty. If we could do it all over again, this is not the system that anyone—employers, insurers, consumers and hospitals—would dream up.

Appearing before us today on the first panel are experts who can describe how we got here and what we might do to change the system. On the next panel, we have distinguished representatives from hospitals as well as an expert on government pricing, who can bring some real world experience to bear on this very difficult problem. I welcome you all and look forward to your testimony.

I am now pleased to yield to our ranking Democrat, Mr. Pomeroy.

Mr. POMEROY. Mr. Chairman, thank you very much, and I am delighted to be participating in today's hearing. I do think that our work might have been achieved perhaps more successfully had the focus of this morning's hearing been a little more straightforward. I am not entirely clear whether we are exploring tax-exempt status or whether we are exploring hospital pricing practices, and I believe they are somewhat distinct points of inquiry. I think each represents an interesting area for us to explore, but to look at the pricing practices of tax-exempt hospitals seems unnecessarily confusing, leaves open the question of whether or not we are concerned about the pricing practices of non-tax-exempt hospitals, and leaves us somewhat wondering where this is going in the first place.

I think that, as I mentioned, there are some interesting things we can pull out of it. Transparency in pricing has got great value, and not just for hospitals. Actually, we have to think about that a little more, in government as well. I voted for a Medicare prescription drug bill (P.L. 108–173) I thought cost $400 billion. Come to find out it cost $536 billion. You know, some might think I should not have voted for that bill. I just wished I had known the price,

and made a determination in light of the true price, not the price that was represented, that maybe some representing it knew wasn't the actual price. So, transparency in pricing is an important business.

I also think the business of how we establish pricing specifically in hospitals is quite interesting, because most of the people accessing hospital services have some kind of third-party coverage. Obviously, Medicare sets prices for the part covered by Medicare. Private insurance companies negotiate prices for the people that access care under their health insurance coverage, for the portions of copays are now Health Savings Accounts (HSAs) first-tier exposure. They will still get the discounts negotiated by their insurance companies, and then that leaves the uninsured, Mr. Chairman, as you note, without someone negotiating those discounts, and they are subject to the charge master. I think that for a second, 1 second, for anyone to suggest that the problems of the uninsured are really pricing practices misses the point. It is not whether there is transparency behind those prices, it is the reality that if you are uninsured you have pretty significant prospects. You cannot afford the cost of medical care in this day and age, and the problems of the uninsured deserve its whole additional focus.

The pricing issue, in and of itself, is a creation of the fact that we have several different ways people are covered for health insurance, and some not covered at all. If we are going to really get to the bottom of that one, we might want to take it back to the Subcommittee on Health, the Subcommittee jurisdiction on this matter, and proceed an investigation of the uninsured. That might have some significant value as well.

These are all kinds of questions swirling around in my mind. The tax-exempt status is another issue. If there is indeed a significant record to establish that institutions, charitable in construct, tax-exempt in status, are not meeting what is expected of them under the Code to achieve that status, that is an inquiry I think would have broad interest across the full Committee on Ways and Means, and I look forward to getting to the bottom of that. Again, trying to get to the bottom of that in a hearing on pricing practices, to me puts us on a circuitous route to that important question. In summary, Mr. Chairman, even though I feel like I am kind of climbing in a car I don't know where it is going, I am not even entirely sure why we are taking this trip, as long as I know you are along, Mr. Chairman, I am happy to be along for the ride. I yield back.

Chairman HOUGHTON. That is a pretty weak reed to lean on, I can tell you that. Mr. Thomas, the Chairman of the Committee on Ways and Means, would you like to make a statement?

Chairman THOMAS. Just briefly, Mr. Chairman. Thank you for the beginning of what I hope is a long process, since this is the Subcommittee on Oversight, the Subcommittee correctly charged with reviewing for the Committee issues and items already on the Code, or the manner in which we should change differences in the Code.

I listened with interest to my friend from North Dakota, Mr. Pomeroy, and the verbal statement that he delivered as his opening statement deviates from his written statement in referring to the $400 billion versus $500 something billion from the Adminis-

tration. I guess that was necessary to insert in this hearing, but it really does underscore why hearings like this need to take place.

The $400 billion was the number determined by the Congressional Budget Office (CBO). Those individuals and institution under the law, which we are required to rely on to provide us with estimates, not once, but twice. After reviewing the legislation, CBO said that it was going to cost $400 billion. The gentleman is referring to another branch of government, the executive branch, which makes its own estimates, and I find it ironic that at times when they are arguing about particular policies or budgets, they prefer to hang on to CBO, rather than Office of Management and Budget (OMB). In this instance somehow, OMB is now the yardstick, and CBO is not. I find that when people choose different partners at different dances, it tells me something.

In addition, I invite all of you to read the article in The Hill newspaper on Thursday, June 17, only to illustrate that it is possible to be consistently wrong over time. The gentleman who writes the article refers to me and my relationship on this issue to the late nineties. Someone needs to know I have been involved with this since the early eighties, and it seems to me that once every 20 years is not outlandish to review an area of government policy that involves billions of dollars.

If you will go back and look at the history of the 501 or so-called charitable or nonprofit portion of the Tax Code, you see significant shifts in the 'thirties and in the 'fifties, and really no significant difference since the 'fifties.

I have asked Chairman Houghton, and I hope the gentleman from North Dakota will be a willing partner, to investigate the entire 501(c) section. When examining the entire 501(c) section, it seems prudent that you would look at those areas that involve themselves most extensively in the expenditures which occur under 501(c). Hospitals comprise 41 percent of the expenditures in this area. Why wouldn't you start with the group that gets the biggest, largest break?

The second reason I think it makes sense to go with hospitals is that when you look at other activities that are covered under 501(c)(3), there probably isn't as good an example, although 85 percent of the hospitals in the United States are not-for-profit. If I blindfolded you, took you into a hospital, took the blindfold off you and led you around to look at the hospital, you would be hard pressed to determine whether it's a 501(c) not-for-profit or a for-profit. In other words, here are two institutions structured fundamentally differently in the Tax Code, carrying out virtually identical duties, the responsibilities and functions as a hospital. The Chairman, in his opening statement, illustrated some things that not-for-profits do, which used to be called charitable—now it is called community benefit—in nature. We don't know if for-profits do that either, and if in fact there are as many for-profits that can be shown to give a break to low income as not-for-profits, then that is not really a difference for receiving that tax benefit. What is it that they do differently than people who pay taxes? We owe it to the taxpayers to explore that question.

When we were debating Medicare, a portion of Medicare that we talked about and got to know real well is a portion called bad debt.

It is payment to hospitals in lieu of hospitals not being able to collect money from people who can't pay. Hospitals can't collect their bills, so taxpayers pay the money. If you pay the same amount to for-profit as not-for-profit since not-for-profit gets a tax break that for-profits don't which is supposed to be under a community or charity concept? We don't know. I do not understand the resistance in the community to getting some knowledge to the Members of Congress who are charged with the responsibility of overseeing the Tax Code, and that if this hearing does not provide us with sufficient understanding of how someone who in one situation is not-for-profit and the other one is for-profit, and there is no real difference between the two, why the expenditures? If there is a difference, where is the difference? How is it a difference? How, in going through the rest of the 501(c) can we begin to build a case to see if others merit, if in fact not-for-profit hospitals do, the differential that is in the Tax Code?

Mr. Pomeroy, your concern about the pricing goes right to the heart of our problem to differentiate between not-for-profits and for-profits, because you would at some time and under some circumstances, the not-for-profit aspect would display a different behavioral profile than the for-profits, and that is basically what we are going to try to do. We started with hospitals because they are the biggest chunk. They also give us an example to compare, ostensibly, to similar operations that are structured significantly differently under the Tax Code. So, I think it is most appropriate that we start with this area. One of the most confusing areas of hospitals, whether they are for-profit or not-for-profit is the pricing. So, if you are going to investigate how they are different or similar, it makes all the sense in the world to begin to talk about pricing.

With those opening statements, Mr. Chairman, I want everyone to know that this is the beginning of a very long series of hearings dealing incrementally, moving down the tax expenditure amount structure, to a number of institutions that are in direct competition with for-profit institutions in this society for which they receive significant tax benefits under the 501 category, and what is it that taxpayers are getting for the billions of dollars that are forgiven because of the categorization one way or another. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you, Mr. Thomas. Mr. Stark, would you like to make a statement?

Mr. STARK. Thank you, Mr. Chairman. Thank you for inviting me to join with you today. I too am confused. I have reviewed the testimony, and there is nobody that talks about the difference in prices except Ms. Davis, who happens to be our witness, and I am not sure she has any charts. So, if this is a hearing to determine whether there is a difference in pricing between profits and nonprofits, we should send the witnesses home and ask them to come back with some examples.

There is a lot we could do to improve our health system, but I think we need to talk more about coverage for 44 million uninsured, not how to lower hospital bills. I think it is a given that patients don't select hospitals, their doctors do. Even if you had price transparency it would be foolish for people to choose a hospital on price alone without information as to what the quality of care is,

and what happen—and most of us who are not physicians, don't have the foggiest idea of what is going to happen to us when we enter a hospital, so we wouldn't know what to ask or how to compare. It is one thing to compare a Chevrolet with a Ford with the help of the Internet, I suppose, but I would ask any of you to tell me what the difference is in a pap smear or a proctoscopic examination unless you have gone through it. Until we can determine the quality of services and combine that with cost, it seems to me we are wasting our time.

As to whether or not we ought to give tax exemption to hospitals, that seems to me to be a whole other issue and I would suggest that the real burden is to define, which we have been unable to do, certainly in the 30 odd years I have served on this Committee and the previous experience on the Committee on Banking, which used to have jurisdiction over the nonprofits, there is no definition of charity care for hospitals that a Certified Public Accountant (CPA), that Financial Accounting Standards Board (FASB) has. Is it a bad debt forgiven or is it a scholarship when you walk in the front door? Absent that, which happens to drive the disproportionate share of discounts, it is an important thing for us to know.

I would hope, Mr. Chairman, that we could look at that some more, so that we were able to define as to who gives charity care and who just doesn't have such good debt collectors, and that would be very useful to us in the future, but I hope maybe we can, in questioning, elicit some of that on some suggestions as to how we proceed from the witnesses. Again, thank you for allowing me to join you.

Chairman HOUGHTON. Thanks, Mr. Stark. Mrs. Johnson, would you like make a statement?

Mrs. JOHNSON. I thank you, Mr. Chairman, and indeed, I congratulate you on this hearing, and I am starting out on this thoughtful trek in terms of what does nonprofit status, which is a tax subsidy, gain us for those who enjoy it, and what is the relationship between those institutions that enjoy a privileged tax status and other institutions that provide like services that don't enjoy a privileged tax status.

I am here not because I am a Member of the Subcommittee on Oversight, but because I am Chairman of the Subcommittee on Health, which has a different responsibility. One of our responsibilities that we are having great difficulty managing was well reflected in the Medicare Modernization bill. It asked for a number of studies and efforts for experts to better define that the information that we rely on in setting rates, and indeed, this afternoon we have a seminar of our Subcommittee with the Medicare Payment Advisory Committee (Med PAC) on their first report of how difficult it is to find data that will tell us what your financial circumstances are, and this issue of your having a defined amount that you charge people, that then varies all over the place, is one of the reasons it makes it very hard for us to figure out what your financial circumstances are. There is enormous conflict between what we call the Medicare margin and your total margin. This conflict has been so great, you can't make logical policy any more without better understanding these differences.

We are going to be taking on a lot of the issues associated with how do we evaluate whether or not our hospitals are financially stable, doing well, and fairly rewarded, and part of that is the nonprofit benefits for those that are nonprofits versus the for-profits. So, this is a different angle on something we are interested in. We do not have time nor researchers to do it. I am glad they are doing it. I am here to listen to that. There are going to be many aspects to hospital financing that we are going to look at, and the reason we are going to look at them is that if we don't community hospitals are going to be destroyed by the public and private reimbursement systems that are supposed to support them.

You look at what surgi-centers have done to hospitals in terms of taking out the simple programs, the simple cases. You look at what boutiques hospitals are positioned to do. You look at what competition for lab services are positioned to do, and you can't believe that community hospitals will be here for charitable or any other purpose if we don't get more honest and clear headed about what it is we are paying for and under what circumstances.

So, this hearing, to begin to sort out what is the nonprofit subsidy that goes to hospitals and what is it related to, and what do we think of it, and what is it costing us, is all a very, very important piece of the program, and then we need to look at not only hospitals as nonprofits but the nonprofits across the board. I don't know what other Members are finding, but I am deluged with applications for 501(c)(3) status, and we need to understand as a tax writing Committee what is the effect of the nonprofit tax subsidy structure that we put in place many years ago with a very simple rationale, but which has absolutely exploded in multiple directions.

I commend Chairman Houghton and Mr. Pomeroy for starting out this series of hearings which I think is extremely important for our tax writing Committee, and I am pleased to be here as the Chair of the Subcommittee on Health because these issues are always interrelated. I thank the Chairman for the courtesy of being able to make this comment on the record. Thank you.

Chairman HOUGHTON. Thanks, Mrs. Johnson. Unless anybody has a burning desire to make an opening statement, I think we will go right to the panel.

Mr. KLECZKA. Mr. Chairman, I don't have a burning desire except to insert two articles into the record at this point. Mr. Chairman, I would ask unanimous consent to put this hearing into perspective, that two articles be entered into the record. The first is The Hill article dated June 17, and it is entitled, "Congressional Inquiry Triggers Hospital Angst." The second is a BusinessWeek article from June 7, and the article is entitled, "Making Hospitals Cry Uncle."

Chairman HOUGHTON. Fine. We will put them in the record. Thanks very much, Mr. Kleczka.

[The information follows:]

Congressional inquiry triggers hospital angst

By Bob Cusack

In a move that has attracted attention on K Street, a powerful House lawmaker with a long memory has launched an investigation into the financial practices of the hospital industry.

Hospital lobbyists fear that the scrutiny could eventually lead Congress to make changes to the industry's tax-exempt status.

Some healthcare experts believe it is no coincidence that House Ways and Means Committee Chairman Bill Thomas (R–Calif.), who is spearheading a broad review of all 501(c)(3) tax-exempt entities, picked hospitals as his first target.

Thomas and the hospital sector have had a complicated, roller-coaster-like relationship. In the late nineties, Thomas protected the industry from proposed Clinton administration cuts in Medicare reimbursements.

But in 2002, the relationship soured after a draft of the House Medicare reform bill was leaked to the media. Thomas believed then—and believes now—that hospital Medicare payments have become bloated and need to be curbed.

Hospital groups rallied against the 2002 measure, claiming that it could slash billions of dollars they receive from Medicare. The intense lobbying effort worked, and an infuriated Thomas was forced to rewrite the legislation.

At the time, sources close to Thomas vowed that the lawmaker would get his way eventually—most likely in a nonelection year.

"Thomas remembers everything," an industry lobbyist said, adding that hospital groups are nervous that Thomas is laying the groundwork to scale back hospital payments next year.

"He may tell [hospitals], either accept Medicare payment changes or lose your tax-exempt status," the lobbyist said.

A hospital lobbyist agreed, saying, "That's Thomas's style."

On Tuesday, the largely inactive Ways and Means Oversight Subcommittee will hold the first of a series of hearings on tax-exempt issues. In announcing the hearing, the Committee took some veiled shots at the industry: "Hospital charges are not transparent. So consumers, including the uninsured, do not have access to information on the costs of medical treatment across hospitals."

The release cited Medicare figures, claiming that "hospitals' charges exceed their average costs by 118 percent."

There are more than 300,000 reporting tax-exempt 501(c)(3) entities. Hospitals represent 1.9 percent of total reporting charitable 501(c)(3)s, but accounted for 41 percent ($337 billion) of total expenditures, according to the Ways and Means panel.

ne healthcare expert estimated that 80 to 85 percent of all hospitals are tax-exempt.

Thomas last month defended the inquiry, saying that taxpayers deserve to know what they are paying for. He told reporters, "I know a lot of people don't want me asking these questions, but we are talking about billions of dollars."

Earlier this year, the hospital industry suffered a public-relations hit when it claimed that government regulations were causing it to charge uninsured patients higher-than-normal prices. In a rare move, the Bush administration in February released the full text of its response letter to the American Hospital Association (AHA) disputing the contention government rules dictate hospital charges for the uninsured.

Hospital lobbyists are anxious that Ways and Means aide Deborah Williams is taking the staff lead on the investigation. Williams, who helped draft the new Medicare drug law, is very familiar with the ins and outs of the hospital sector, having previously worked for AHA.

But to the industry's dismay, Williams is a vocal proponent of slowing the growth of hospital reimbursements.

Making Hospitals Cry Uncle

Has insurer J. Patrick Rooney found an unorthodox way to turn up the heat?

Conservative millionaire J. Patrick Rooney is on a mission from the Almighty: Bring down crushing and "ungodly" health-care costs. For more than a decade, he has worked to replace traditional insurance with tax-free health savings accounts (HSAS), which people can use to pay for their own medical care. "I'm doing the right thing, and I think the Lord will be pleased about it," he says.

Using his fortune to open doors in Washington, Rooney has relentlessly preached his gospel. Last year, Congress saw the light: GOP lawmakers inserted a $6.4 billion tax break for HSAs into a Medicare prescription-drug bill. And a recent survey by Mercer Human Resource Consulting says 75% of employers are likely to offer the accounts by 2006.

A courtly 76-year-old, Rooney has never hidden the fact that he stood to profit from his crusade. After pioneering HSA sales with his old company, Golden Rule Insurance, he sold out to UnitedHealth Group Inc. (UNH) for $893 million just be-

fore Congress passed the tax break. He promptly founded Medical Savings Insurance Co. to sell more HSAs.

PR HARDBALL

But Rooney isn't relying on just the power of his ideas and political connections to make his company profitable. The Indianapolis-based insurance entrepreneur also is backing a nonprofit group that uses hardball tactics to get hospitals to cut prices. The nonprofit, called Consejo de Latinos Unidos, campaigns on behalf of uninsured Hispanics.

Last year, Consejo pressured the nations' No. 2 hospital system, Tenet Healthcare Corp. (THC), to cut rates for uninsured patients and revamp its collection practices. At the same time, Rooney's Medical Savings won about $2 million in debt forgiveness from Tenet.

Now, Consejo's leader, Republican strategist K.B. Forbes, has turned his attention to Florida. Hospitals being pilloried there say Rooney's company owes them millions in unpaid bills, too. And Rooney has suggested that a new Consejo target—HCA Inc. (HCA), America's largest hospital operator—could take a lesson from Tenet and shake its bad press by cutting a deal to forgive Medical Savings' debts.

Rooney, who pledged seed money to Consejo and hired a Washington public relations firm to draw attention to its cause, says he doesn't control Forbes. "K.B. has to paddle his own canoe," Rooney says. Besides, says Rooney, his drive to cut healthcare costs, especially hospital fees, is about more than money: It's a moral crusade. As such, he makes no apologies for unorthodox methods.

ARM-TWISTING?

That includes backing Forbes, a onetime Medical Savings employee. "Forbes presents himself as an advocate of the consumer," says Linda S. Quick, president of south Florida Hospital & Healthcare Assn. But Consejo "seems to be initiated and financed by Rooney and others selling individual insurance."

With his folksy demeanor, Rooney comes across as an endearing do-gooder. He is also one of the most powerful voices on the Right. Since he pioneered HSAs in 1990, Rooney, his family, and employees have poured more than $5 million into Republican causes.

Rooney's new model of health coverage, which has won support from President George W. Bush, replaces traditional insurance with tax-free health savings accounts and high-deductible policies. The argument: If patients must pay out-of-pocket for, say, the first $1,000 in bills, they will seek more cost-effective care. That, Rooney maintains, will unleash market forces to hold down costs. Big insurers, including Aetna Inc. (AET) and many regional Blue Cross Blue Shield Assn. plans, began rolling out HSAs this year.

For hospitals, the plans pose a threat: bad debts. Patients accustomed to first-dollar coverage find they must pay before insurance kicks in, and many don't. In April, HCA blamed a rising tide of unpaid bills for its soft first quarter.

It's not just patients who aren't paying. Medical Savings routinely marks down its policyholders' hospital bills by as much as 80%. "Yes indeed, we're making unilateral decisions," Rooney says. "But by God, we have to hold the hospitals down to a reasonable price." Medical Savings tells providers to accept its checks as full payment—or collect from patients.

But as Forbes has demonstrated, hospitals pursuing low-income patients are vulnerable to attack. Last year, Consejo stoked press coverage of poor patients being hunted down by bill collectors. "Nobody wants these cases where someone was sick and the big, bad hospital is suing them," says Richard Morrison, a vice-president at Orlando's Adventist Health System, which says Medical Savings owes it some $1 million.

Consejo zeroed in on Tenet in 2001 after Forbes uncovered examples of bare-knuckle collection practices—such as a lien on a Louisiana patient's beat-up mobile home. His timing was perfect. Tenet was trying to acquire hospitals in four cities and had drawn fire from the feds over its Medicare billing. At critical junctures, Forbes would trot out patients to portray Tenet as intent on gouging the poor. Tenet lost three of the acquisition deals.

Behind the scenes, Tenet was in talks with Medical Savings over its unpaid bills. In January, 2003, Tenet caved. It forgave nearly all of Medical Savings' debt and lowered prices for the uninsured. In return, Consejo dropped 10 lawsuits. The deals with Consejo and Rooney were "contemporaneous and simultaneous," a Tenet executive says.

Like Tenet, HCA has sought a truce. In mid-2003, Chairman and chief executive officer Jack O. Bovender Jr. set up a meeting with Rooney to explain HCA's discount policy in hopes that Rooney would persuade Forbes to back off. But prior to

the meeting, Rooney forwarded a memo to Bovender from Medical Savings President Randy Suttles that drew parallels between HCA's situation and Tenet's. In the memo, which HCA made available to BusinessWeek, Suttles notes that Tenet had shaken some of its bad press after making a deal with Medical Savings. "HCA is in similar circumstances," Suttles wrote. A livid Bovender canceled the meeting.

When asked about the e-mail to Bovender, Rooney says: "The one thing hospitals can't afford is a loss of public trust." And he isn't afraid to get in their faces. "If we go to the hospital and beg, they'll say: 'We'll give you 20% off,'" says Rooney. "Well phooey—that's still an outrageous price. And we're not going to pay it." Indeed. More than 20 Florida hospital groups—including HCA—are suing Medical Savings for some $7 million in overdue payments.

HCA and other Florida hospitals figure they have better odds of bucking Forbes and Rooney than Tenet did: They're not under serious regulatory scrutiny, and they're moving to help the uninsured. Rooney paints a different picture, saying hospitals are lining up to deal: "Tenet is not the only one." Both he and Forbes—independently, of course—predict victory.

By Lorraine Woellert in Washington

Now, going to the panel. Nancy Kane, Professor at the Harvard School of Public Health in Boston; Paul Ginsburg, President of the Center for Studying Health System Change; Peter Lee, President of the Pacific Business Group on Health in San Francisco; Karen Davis, President of the Commonwealth Fund; and Regina Herzlinger, the Nancy McPherson Professor at the Harvard Business School in Boston. Please begin your testimony, and Dr. Kane, would you start?

STATEMENT OF NANCY KANE, PROFESSOR OF MANAGEMENT, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MASSACHUSETTS

Ms. KANE. Thank you. I just want to correct. I am a Professor at the Harvard School of Public Health, not the Harvard Business School. Mr. Chairman and Members of the Committee, thank you for inviting me to come and talk about medical bad debt and hospital tax exemption under the guise of hospital pricing practices.

I think I wanted to start by talking a little bit about medical debt because it is a growing public health problem. Besides causing an enormous financial burden on some of our most vulnerable citizens, including personal bankruptcy and the loss of their homes, and the garnishment of their wages, it causes these people to be at an enormously greater health risk. The people who incur medical debt do not follow up on life threatening conditions such as getting the lump out of their breast for breast cancer and then not going back for the chemotherapy or the radiation therapy. People with less critical conditions don't go to the physician and do not fill needed prescriptions, and people who have incurred medical debt don't let their children participate in sports and do not undertake physical activity for fear of incurring an injury that might add to their medical debt. If we are concerned about obesity in this country, it doesn't help to have people afraid to undertake physical activity.

Medical debt is related to the fundamental flaws in our health care financing system, which is both voluntary and extremely expensive, and increasingly out of the reach for a growing number of people in this country. Hospital pricing practices make a flawed

system even worse by charging people who are self-pay, and therefore usually uninsured or at risk for a deductible or a coinsurance, it charges them the highest prices available. The hospital pricing system is now based on market-based negotiations, and the self-pay are not in a very good bargaining position when they arrive at the hospital door, or when they try to seek information on the Web, they are not asked what they would like to offer for that care when they are seeking care.

So, the self-pay and only a few indemnity carriers are left paying on the basis of hospital charges, the charges are set indeed to cover the negotiated discounts of everyone else. Historically that made some sense, back when the discounts were around 16 percent, back in 1982, and many more payers were indeed paying on the basis of charges, and in fact, many hospitals were encouraged to do that by the rate setting systems in various States. However, rate setting has disappeared and negotiated pricing has taken place.

Negotiated pricing now has brought those discounts up to 46 percent in 2002—that is the median, by the way, not the average, which is probably higher—therefore, the markup of charges over hospital costs has grown from about 120 percent of cost to 180 percent, and again, that is the median. Fifty percent of hospitals are at or below, and 50 percent are above 180 percent markup of their hospital charges over cost. Obviously, charges are wildly unrelated to cost, and other activities that hospitals undertake to specifically set charges to discriminate against either charge payers or Medicare outliers has made the charges even more wildly unrelated to cost.

Now to talk a little bit about the medical bad debt and the free care. Free care is only about 1 percent of hospital charges. That is the amount that is forgiven by hospitals. The determination of who is eligible for free care is generally up to the hospital's board and the hospital's management. A few States regulate a minimum amount of eligibility in terms of a person's income level, and I believe one of the Members described some of the range in eligibility—actually, I think it was the Chairman. It is wildly variable from State to State and hospital to hospital whether an individual will be eligible for free care. You can be at 100 percent of Federal poverty level and still not be eligible for free care in some States and in some hospitals. Even if you are eligible, you may not be aware that free care is available.

Bad debt is another 3 or 4 percent of hospital charges, and from the information I have gotten on some small surveys, definitely not a national database, about half of the bad debtors in hospitals are insured people trying to deal with high deductibles and coinsurance and copayments. The tax exemption, as I have just heard from the Members of the Committee, hasn't been reviewed in a long time, and clearly is not tied to the provision of charity care of community benefit, and it led to the kind of attitude that I got back in the years that I have been involved with local communities charging tax-exempt challenges, a former hospital chief executive officer (CEO) informing me that it is just as charitable to serve a rich man as a poor man.

Most of the challenges are coming from State and local authorities. The Federal government, the Internal Revenue Service (IRS)

is really pretty weak in terms of encouraging greater charitable on the part of nonprofit hospitals. I see my time is up. In terms of transparency of pricing, you can see I don't think it is going to have a huge impact on the uninsured. Many of them are not allowed into the hospital until their care is an emergent condition. Therefore, shopping around for a price is really not going to help them, and I will end there. Thank you.

[The prepared statement of Ms. Kane follows:]

Statement of Nancy Kane, Professor, Harvard Business School, Boston, Massachusetts

Medical Bad Debt—A Growing Public Health Crisis

Mr Chairman, Committee Members: Thank you for the opportunity to comment on pricing practices of hospitals, particularly in regard to their contribution to the growing public health problem caused by personal medical debt in the United States. Medical debt is the second-leading cause of personal bankruptcy.[1] Medical debt deters debtors from seeking needed medical care on a timely basis. It.also causes them to change their lifestyle in unhealthy ways, such as restricting their children's participation in sports for fear of an injury, not saving money for future retirement, and dealing with daily stress due to harassment of aggressive debt collection agencies who may put liens on their home or garnish their wages.[2] Even insured people incur medical debts; low-income insured people, like low-income uninsured people, do not fill needed prescriptions, skip follow-up treatment for life-threatening diseases like breast cancer, and do not see a physician when suffering acute illnesses.[3]

Hospital Pricing Policies—Background

As you have become aware, hospitals charge self-paying patients based on their "list prices", known in the industry as gross charges. Hospital gross charges evolved in a different payment era, 30–40 years ago, when many more people were covered by commercial insurance under "indemnity" products that allowed people total freedom of choice of provider; the insurer paid for unbundled units of service like lab tests and the recovery room. Charge masters were inches-thick books listing hospital charges for thousands of individual items. Because the patient could go anywhere for care, most commercial insurers did not have a meaningful context for contracting with a network of providers for discounted prices. Charges were set at a level for the hospital to recover "shortfalls" related to non-charge-paying insurers (Medicare, Medicaid, some Blue Cross Plans) and to patients who couldn't or wouldn't pay their bills. In the late 1970's and early 1980's many hospitals developed software that identified which hospital services were most heavily used by charge-payers, so that they knew where it was most profitable to raise charges; this "revenue-maximization" method of setting charges for individual units of service contributed to prices that today can be wildly unrelated to cost.

In the 1990's, as privately-insured patients were driven into PPO (preferred provider organization) and HMO products with restricted networks, insurers were able to negotiate hospital payment terms based on bundled service units such as DRGs, all-inclusive per-diems, and capitation contracts, although some still use fee schedules and discounted charges particularly for outpatient care. Unfortunately, with no large insurers to represent them, self-paying patients were left paying on the basis of hospital gross charges. With fewer patients paying charges, many hospitals raised charges even higher above cost to cover ever larger contractual shortfalls. The median markup (the ratio of hospital gross charges to total cost) was only 120% in

[1] Jacoby MB, Sullivan TA, and Warren E. "Rethinking the debates over health care financing: Evidence from the bankruptcy courts." New YorkUniversity Law Review, Volume 26 (2), May, 2001.

[2] Daly HFT, Oblak LM, Seifert RW, Shellenberger K. "Into the red to stay in the pink: the hidden cost of being uninsured." Health Matrix: Journal of Law-Medicine. CaseWestern ReserveUniversitySchool of Law. Volume 12 (1), Winter 2002.

[3] Commonwealth Fund Quarterly, Summer 2002, p.8

1982, but gradually rose to 180% by 2002. At the same time, the median contractual "discounts" rose from 16% in 1982 to 46% of charges in 2002.[4]

Many self-pay patients do not have the resources to pay those bills; on average, patients classified into the bad debt and free care categories ("uncompensated care") pay only about 20% of the cost (not charges) of their care.[5] However, depending on how those patients were classified at the time they received their care—as bad debt or as free care recipients—their lives after receiving hospital care are dramatically different.

Charity Care versus Bad Debt—Implications for the Patient

If the patient is deemed eligible for "charity" or free care under the hospital's guidelines for eligibility, then the charges are not billed and the hospital does not attempt to collect from the patient. Policies determining eligibility for charity care are determined by individual hospitals in most states, although a few states regulate minimum standards. State or hospital eligibility guidelines range from a family income at or below 100% of federal poverty level to family incomes as high as 300% of federal poverty level; sometimes a sliding scale for discounts off hospital charges is available for families with incomes above some minimum, eg between 100 and 300% of poverty level.

If a person does not qualify for charity care, and is unable to pay the bills either because s/he is uninsured and not wealthy, or is insured but has copayments, deductibles, or coinsurance that are beyond his/her means, then the person becomes a medical debtor. Some hospitals turn late medical bills over to highly aggressive debt collection agencies, whose tactics have been well documented recently in the press. The bill to the uninsured bad debtor is based on hospital charges unless the hospital has a program of sliding scale discounts to assist patients who cannot afford their medical bills but are not eligible for charity care. The amount that insured patients owe reflects their insurance plan's deductible and copayment or coinsurance policies; policies with coinsurance and deductibles as high as $15,000 are becoming popular in the individual market as deeper coverage becomes impossible to afford.

Medical bad debt is a growing problem for both insured and uninsured families and individuals. In a recent survey of hospitals in Maine, for those hospitals that kept track of the source of bad debt by insurance status, 40–50% of the bad debt was owed by people with private health insurance. According to one study, 80% of families in bankruptcy due in part or in whole to medical bills had medical insurance.[6]

Hospital Tax Exemption and the Provision of Uncompensated Care

The provision of charity care or a sliding scale discount for patients deemed "bad debtors" is not a requirement for hospital tax-exemption at the federal level. Some state and local taxing authorities have challenged hospitals that fail to provide a "reasonable" level of charity care to patients, but most states have been reluctant to specify a quantity of charity care that hospitals must provide in order to retain their state and local exemptions. Research done by myself and others in the mid-1990s indicated that the quantifiable value of hospital tax exemptions greatly exceeds the average *cost* of charity care provided. In my research sample in 1995, 75% of hospitals enjoyed tax benefits in excess of the average cost (not charges) of charity care provided. Even when the average cost of bad debt was included in my analysis, roughly one-third of hospitals in my national sample of 521 hospitals had excess tax benefits.[7]

Multiple Transparency Issues

The transparency problem in charity care is that many people who would have qualified for charity care didn't know that it is available because the hospital did not publicize it. Failure to inform patients of the availability of charity care is one of several reasons for recent lawsuits and tax-exemption challenges against Yale-New Haven Hospital and Provena Health in Illinois, among others.

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[4] 1982 from Cleverley, WO, Hospital Industry Analysis Report, 1979–1983; 2002 data from the Almanac of Hospital Financial Performance, Ingenix, 2004.

[5] See hospital payment-to-cost ratios by payer in the MedPAC June 2000 Report to Congress, Table C12; bad debtors fall into the "uncompensated care" payer category.

[6] See footnote 1, above

[7] See Kane NM and Wubbenhorst WH, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." The Milbank Quarterly, Vol 78 (2). 2000.

From a health policy perspective, a related transparency failure is the lack of a publicly available national data base on hospital free care, bad debt, and the other financial elements needed to estimate the value of hospital tax-exemptions. This committee would be doing a great public service if it were to recommend the creation of such a national data base, which could be relatively easily done through improved reporting on the Schedule G of the Medicare Cost Report.[8] Policymakers at both state and federal levels would be better able to reform tax exemption policies or to challenge hospital practices if they could document current levels of bad debt, free care, and the value of tax exemption.

Transparency of hospital charges would add some value to uninsured patients facing the possibility of medical debt—especially if prices can be stated meaningfully rather than in the form of a traditional hospital charge book. Already some medical information companies have developed web-based information tools for consumers to "shop" for specific, well-defined procedures and medical conditions for which consumers have time and incentives to do comparison pricing, particularly if they are at risk for co-insurance or the whole bill.

For the uninsured, however, hospital price transparency may be of limited value except for predictable *and* urgent events like childbirth (which is a common reason for incurring bad debt among the uninsured). Many hospitals have a stated policy of not providing charity care and not extending credit to uninsured patients for non-urgent conditions; uninsured patients must pay cash up front before receiving "elective" treatment. The line between urgent and elective is subject to some interpretation, especially with the growing burden of chronic disease present in our society. In any case the result is that uninsured people avoid seeking care until the need is urgent or life-threatening, because the hospital must treat them, and some would then qualify for charity care. This pattern of behavior limits their options to hospitals in close proximity that are not on emergency diversion status at the time of their urgent medical need. Pricing considerations are not likely to influence where one ends up under these circumstances.

Summary

Transparency in hospital pricing would be a useful supplement to stronger policies that reinforce the safety net for the uninsured. One such policy would be to strengthen the tie between hospital tax exemption and the provision of medical services to the uninsured. Hospitals could be required to demonstrate how they "earn" the value of their tax exemption, with higher priority, safety-net activities counting for more than those activities that primarily benefit insured populations, the hospital's competitive position, or the general public. Incentives for hospitals to provide preventive, primary, and chronic care to vulnerable uninsured populations could both save money and greatly reduce human suffering.

Thank you for the opportunity to speak.

Chairman HOUGHTON. Thanks very much, Ms. Kane. Dr. Ginsburg, you may begin your testimony.

STATEMENT OF PAUL B. GINSBURG, PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Mr. GINSBURG. Mr. Chairman, Mr. Pomeroy, and Members of the Subcommittee, I appreciate the invitation to be here to present testimony on hospital pricing issues. I am President of the Center for Studying Health System Change, which is an independent nonpartisan health policy research organization funded principally by the Robert Wood Johnson Foundation.

After a respite in the nineties, health care costs are rising rapidly again. In 2003 hospital price increases were an important factor behind the increases in costs faced by those who were privately

[8] See Report to the Congress, June 2004, Sources of Financial Data on Medicare Providers, Medical Payment Advisory Commission; also KaneNM and Magnus S. The Medicare Cost Report and the Limits of Hospital Accountability: Improving Financial Accounting Data. Journal of Health Policy, Politics, and Law, Feb. 2001:Vol 26 (1):81–105.

insured. Employers have been changing their health benefit plans to emphasize patient financial incentives to use less care and to be sensitive to prices. With hospital pricing extremely complex, it is fortunate that at least insured people have more effective mechanisms to purchase hospital care than by attempting to compare incredibly complex hospital charge masters for the services that they are likely to be provided when they are hospital patients. Uninsured people do not have such advantages and unless the hospital offers a lower price on the basis of the patient's income, they pay the highest prices, as Nancy Kane pointed out.

Consumers who are insured benefit enormously from relying on an intermediary to (a) negotiate prices with hospitals, and (b) analyze differences in negotiated prices among competing hospitals. Managed care plans negotiate prices with hospitals through formation of a network of hospitals that have agreed on rates. When the number of people enrolled in managed care plans expanded during the 19nineties, managed care plans were able to negotiate more favorable prices from hospitals. Pressure for broader hospital networks, increasing hospital concentration and capacity constraints have weakened plans' negotiating position with hospitals in recent years.

In order to engage market forces while maintaining broad hospital networks, health plans have developed a new product, tiered hospital networks. Some of the hospitals in the network are labeled as preferred, and consumers are given financial incentives, usually lower copayments, to use them. High priced hospitals risk the loss of some patients, increasing incentives to agree on a lower price. This mechanism reflects a more refined device to incorporate patient financial incentives than say, deductibles, because tiered network incentives are aimed at situations at which patients have choices. Tiered networks accommodate both consumers who do not want their provider choice restricted, as well as those who want to avoid large out of pocket expenses. Nevertheless, tiered network products have grown slowly due to the complexity of the products, hospital resistance, and employer caution.

Consumer-driven plans and HSAs have similar issues concerning hospital pricing. In most situations hospital prices are handled by Preferred Provider Organization (PPO) mechanisms through negotiation. Health savings accounts, I expect, will have networks of hospitals with negotiated prices, and these negotiated prices will apply to the deductible as well, which will be very important to those enrolled in HSAs and consumer-driven plans.

When coinsurance is used, there is a need for the plan to communicate to its enrollees the relative costliness of hospitals. Some plans have been pioneering this by providing ratings like Zagat's ratings of how expensive different restaurants are. For example, California Blue Cross giving from one to five dollar signs for each hospital in its network. Rating hospital costliness is better than revealing negotiated prices. For one thing they are easier for consumers to use, and second, I am concerned that disclosure of negotiated prices will lead to higher prices because of how hospitals will use that information.

The bottom line for consumer-driven health plans, as well as for Health Maintenance Organizations (HMOs) and PPOs is that con-

sumers are better off using their insurer as an intermediary to negotiate lower prices and inform them of the financial implications of choosing Hospital A over Hospital B.

A closing thought: making consumers more sensitive to prices and providing better information on prices and quality can contribute to slowing health care costs, but we should not oversell the potential. In the long run we know that new medical technology is the dominant driver of increasing health care costs. Much of the new technology is terrific, but the lack of careful consideration of clinical effectiveness of new treatments in relation to existing ones leads to more waste and poor outcomes than should be the case. Increased public resources for developing information on effectiveness is critical to the long run slowing of cost increases. Thank you.

[The prepared statement of Mr. Ginsburg follows:]

Statement of Paul Ginsburg, Ph.D., President, Center for Studying Health System Change

Mr. Chairman, Representative Pomeroy and members of the Subcommittee, thank you for the invitation to testify before you today about hospital pricing issues. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded principally by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research.

We conduct nationally representative surveys of households and physicians and site visits to monitor ongoing changes in the local health systems of 12 U.S. communities. We also monitor secondary data and general health system trends. Our goal is to provide members of Congress and other policy makers with unique and timely insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found on our Web site at *www.hschange.org.*

Rising Health Costs

After a respite in the mid-1990s, health care cost trends are rising rapidly again, leading to growing health insurance affordability problems for employers and consumers. At the moment, rising prices for hospital care are an important factor in spending increases for health care covered by private insurance.[1] Although rising input prices, especially for labor, are a factor in rising hospital prices, increased hospital consolidation and consumers' desire for broad hospital choice have enhanced hospital bargaining power with health plans. Engaging consumers through market forces to make more cost-conscious choices about hospital care offers the potential to slow this trend.

In recent years, employers' main strategy to slow cost growth has been to give consumers financial incentives to use less health care and to be sensitive to prices for services. The most important changes for the health care system have involved changes in the benefit structure—primarily increased patient cost sharing—for the health maintenance organization (HMO) and preferred provider organization (PPO) products that most privately insured people have, but consumer driven health plans (CDHP) and health savings account (HSA) plans, which push this approach further, have received more attention. Choosing hospitals on the basis of price, quality and amenities is potentially an important component of this approach. My testimony today focuses on the first—helping consumers incorporate price considerations into their choice of hospitals.

Because of the bewildering complexity of hospital pricing and the uncertainty of what services a patient will need, health plan network designs offer more effective opportunities to engage consumer-driven market forces than extensive publication of hospital price lists.

Putting Price Into the Consumer-Hospital Equation: Theory vs. Reality

In theory, empowered consumers armed with precise information about what care they need would compare information about each hospital's quality, amenities and costs in relation to the benefit structure of their insurance. Their physician, who un-

[1] Strunk, Bradley C., and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Turn Downward In 2003," *Health Affairs,* Web exclusive (June 9, 2004).

derstands what services they will need, would advise them about what those services will cost at each hospital and quality differences among hospitals.

The reality involved in these choices today is far from the theory. Information on what hospital care will cost is available only in forms that are so complex that even the most sophisticated consumers would be overwhelmed. Hospitals charge on a fee-for-service basis that is highly detailed—down to charges for each aspirin. Patients all have different needs, so developing an estimate of what the charge would be for any patient is something that hospitals have not been willing to do. Indeed, many patients are hospitalized to determine what is wrong with them and to determine what treatment is needed.

A number of practical impediments concern the role of physicians. Doctors today know very little about either their patients' insurance coverage or hospital prices. They may have some sense of hospital quality, but this tends to be based on perceptions rather than objective data. Of course, if more of their patients had substantial financial incentives to choose lower-cost hospitals and if information technology were able to put the patient's insurance benefit structure at their fingertips, doctors might become better advisers on these issues.

But doctors often do not practice in all of the hospitals that might be viable options for the consumer. This not only introduces a conflict of interest into the relationship of the physician acting as the patient's agent, but also poses to the patient the reality that choosing certain hospitals will require a change in physician. Indeed, with the increasing presence of physician-owned specialty hospitals, these conflicts are becoming more significant.

Consumer Choice Under Managed Care

Under managed care, health plans serve as an intermediary between the consumer and hospitals to negotiate lower prices for hospital care. This is done not by providing the consumer with a great deal of price information, but instead by forming a network of hospitals that have agreed to a price schedule with the plan. So all managed care enrollees need to do concerning costs is decide whether to limit themselves to hospitals in the network. If consumers use a network hospital, they will in most cases know exactly what it will cost—often a fixed-dollar amount (sometimes zero)—for the hospital stay.

In the 1990s, when most managed care plans had relatively restricted networks of hospitals and physicians, plans were successful in negotiating prices that were substantially lower than they would have been in the absence of managed care. But the lack of provider choice and suspicion that plans placed too heavy an emphasis on cost in developing networks contributed to a powerful backlash against managed care. Employers and consumers demanded broader provider networks, and managed care plans, which are essentially agents of employers, responded by broadening their provider networks. The mechanism of a network remained the same, except that consumers—and their doctors—were happier about the broader choice and plans lost bargaining clout with hospitals because they could no longer credibly threaten to exclude hospitals from plan networks because hospital prices were too high. Tighter hospital capacity and increased hospital consolidation also contributed to declining plan leverage with hospitals. Nevertheless, managed care plans still maintain substantial discounts from what hospitals charge patients with traditional indemnity insurance or those without insurance.

The managed care backlash and the loss of bargaining clout with hospitals from broader networks has led health plans to search for mechanisms that rely more on using financial incentives to steer consumers to lower-cost hospitals. The most important product that has evolved to date is the tiered-hospital network. Within their broad networks, health plans label some hospitals as "preferred." Patients pay less if they choose a preferred hospital but their payments are still relatively modest if they choose nonpreferred hospitals in the network. This provides more bargaining leverage to health plans because hospitals that are not in the preferred tier will lose some volume.

What is attractive about this development is that it can accommodate both consumers who will not accept restrictions on their choice of provider as well as those who are willing to make trade-offs between choice and out-of-pocket expense. Tiered networks are consistent with the newest directions in the use of patient financial incentives, which involve targeting incentives on care decisions where patients have

alternatives.[2] For a number of reasons, these tiered-network products have developed slowly,[3] but they eventually may become significant.

Hospital Choice and Consumer-Directed Health Plans

The large deductible that is a defining characteristic of CDHPs may serve to discourage some hospitalizations, but once a patient is admitted, the deductible will almost always be exceeded. So having a large deductible does not provide much of an incentive to choose a less expensive hospital. Once the deductible has been satisfied, CDHPs typically function like a PPO, with similar incentives to use network hospitals. When there is cost sharing beyond the deductible, it can take the form of a fixed-dollar amount per admission or per day (copayment) or a percentage of the amount that the health plan pays the hospital (coinsurance). It is too early to get a sense of what benefit structures will prove most popular for health savings accounts linked to high-deductible policies, but I would expect them to also function like PPOs so that enrollees can take advantage of health plans' ability to analyze complex hospital price data and negotiate favorable discounts.

Getting hospital price data to the consumer is most important in insurance products that use coinsurance (patient pays a fixed percentage of the bill). If the patient is paying 20 or 30 percent of the bill, prices are relevant, although price differences are diluted by 80 or 70 percent. Blue Cross of California has many products with substantial coinsurance and provides enrollees with hospital cost information using a rating system—from "$" to "$$$$$"—to give patients an idea of how much they will have to pay out of pocket. Such information, which is based on what the plan pays per episode of care, can be a major asset to consumers faced with these types of financial incentives.

Price Transparency vs. Lower Prices

When managed care plans negotiate prices with hospitals, both parties typically agree to keep prices secret. Each side is aware of the possibility that they can get a better deal if their counterpart can keep it secret from others in the marketplace. Whether this leads to higher or lower hospital prices on average in a community depends on whether the health plan or hospital side of the market is more concentrated. Transparency can benefit the more concentrated side of the market because it facilitates taking into account how competitors will respond to prices and aids any collusion. Since hospitals are often more concentrated than health plans at the market level, then transparency would tend to lead to higher prices for hospital care and thus higher health insurance premiums.

The combination of the complexity of dealing with hospital prices and the pitfalls of making negotiated prices public argues for consumers depending on their health plans to negotiate contracts with hospitals and present them with information as to which hospitals will cost them more. This can be conveyed to consumers through differences in copayments (e.g. you will have to pay $300 more to be admitted to hospitals in group A than to hospitals in group B) or communicating which hospitals will result in larger amounts of coinsurance.

A potentially even more powerful tool would be a return to hospital networks that provide less choice, such as the step that the California Public Employees Retirement System (CalPERS) announced on June 16. Some consumers—but not all—would be willing to sacrifice some provider choice to keep their out-of-pocket costs lower. My organization's surveys of consumers have shown a consistent result over time that a majority of consumers are willing to make these trade-offs.

Déjà vu All Over Again

In closing, I would be remiss in not pointing out that today's insurance benefit structures increasingly are returning to coinsurance models similar to traditional indemnity insurance structures. The failure of that insurance model to control costs led to the wide adoption of managed care practices, including restricted choice of providers and tighter administrative oversight of care use. There's no reason to believe that increased patient cost sharing will be substantially more successful this time around in significantly slowing health care cost trends, even if consumers miraculously had understandable price and quality information to help guide their decisions.

Over the long haul, advancements in medical technology are far and away the biggest factor in rising costs. And our current financing system facilitates the rapid dif-

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[2] Trude, Sally, and Joy M. Grossman, *Patient Cost Sharing: Promises and Pitfalls,* Issue Brief No. 75, Center for Studying Health System Change, Washington, D.C. (January 2004).

[3] Mays, Glen, Gary Claxton and Bradley Strunk, *Tiered-Provider Networks: Patients Face Cost-Choice Trade-offs,* Issue Brief No. 71, Center for Studying Health System Change, Washington,D.C. (November 2003).

fusion of expensive new technologies by paying most of their cost—even in the absence of careful consideration of their clinical effectiveness relative to existing treatments. Fundamental change in this dynamic would require support for improved and more frequent evaluation of new technologies prior to decisions about coverage, as well as carefully differentiated incentives built into the financing system that encourage both providers and patients to evaluate the clinical effectiveness of a given course of treatment against its cost.

Chairman HOUGHTON. Thanks very much, Mr. Ginsburg. Mr. Lee?

STATEMENT OF PETER V. LEE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CALIFORNIA

Mr. LEE. Thank you very much, Mr. Chairman, and Members of the Committee for having me join you today on behalf of the Pacific Business Group on Health, which represents some of the Nation's largest purchasers of health care. Our members represent over 3 million Americans in our efforts to both improve health care quality while moderating cost.

Rising hospital costs are a problem nationally, but events in California have underscored that there are three industrywide issues that reinforce Chairman Thomas's note about the blindfolded nature of walking into hospitals, we can't necessarily tell the experience between nonprofit or for-profit. The three issues are first, staggering cost increases, second, huge variations in cost and quality of hospital care, and, third, the failure of the market to address these issues effectively.

While there are multiple issues for the reasons for rising cost, two in particular are the lack of transparency differentiating hospital quality and efficiency, and hospital consolidation, which in many markets has stifled competition. We see variations in cost between and within communities that defy any rational explanation and signal insufficiently competitive markets for hospital services. Gall bladder and heart surgery costs three times as much in Sacramento as it does in San Diego. Cesarean sections cost twice as much in Sacramento as in Los Angeles. The problem is not just high cost. It is also there is a total disconnect between cost and quality. There is no indication that cost differences have any relation to quality. A patient is about twice as likely to have a wound infected in the bottom 25 percent of hospitals as in the top 25 percent; a similar likelihood for getting pneumonia after surgery. Other avoidable complications, and there is no correlation between those quality indicators and cost.

Purchasers do look to their health plans they contract with to ensure that the hospitals are not getting overpaid, and are being rewarded for performance, but also that they provide valid tools so consumers can make better informed choices. Nationally we should have the same expectation of the Center for Medicare and Medicaid Services (CMS) and its administration of Medicare, and I think the good news is we have seen CMS step up to this challenge in important ways. There are four things I think that we need to look at to improve hospital quality and the efficiency with which our care is delivered in our Nation's hospitals.

First we have to expand the availability of standardized performance information. We currently have a Tower of Babel of conflicting and incomplete measures to report on hospital performance. The path to resolve this problem is to support and accelerate the efforts of the National Quality Forum. At the same time, CMS should be not only applauded for its focus on the importance of transparency, but urged to accelerate its efforts to make sure that there is usable information on hospitals and physician performance, and that the information is in the hands of consumers, purchasers and providers. One key element of that transparency is that we must have standards for measuring the relative efficiency with which care is delivered, looking beyond mere unit price to assess the full associated health insurance cost or the longitudinal efficiency with which care by hospitals and doctors is delivered. That is a key measure to be able to understand the difference between for-profit and nonprofit hospitals.

Second, we need to reward better hospital performance. There are large-scale pay-for-performance initiatives in the private sector for medical groups and physicians, and CMS has a new initiative for incentives at the hospital level. Those efforts are promising. Center for Medicare and Medicaid Services (CMS) should not only continue that innovation, but should look actively at how to innovate in partnership with private and State-based public purchasers.

Third, information must be provided along with incentives to consumers to make better choices. Across the country there are a growing array of tools and insurance products provided to health care consumers to help them choose and understand the differences between hospitals, physicians, and treatment options. Consumers want and need this information. Our task is to make sure that that information is valid.

Finally, we have to allow the market to function. We need to be sure that comparative performance information can be used in local markets. There is a danger that in communities that have had hospital consolidation, such efforts will be hindered. Hospitals creating networks is great if that consolidation will help the market to work. It is dangerous, however, if conglomerates of hospitals prevent individual hospitals from having their quality and efficiency show through separately. Conglomerates are dangerous if they prevent separate contracting arrangements with individual hospitals in local communities. I will just note that consumers need to have the information to make informed treatment choices. They don't. Providers need to be paid differently for better performance. Today they aren't. Without those two changes, we will never have a working market to reform hospital delivery. Thank you.

[The prepared statement of Mr. Lee follows:]

Statement of Peter V. Lee, President and CEO, Pacific Business Group on Health, San Francisco, California

Thank you for the opportunity to speak on behalf of the Pacific Business Group on Health, which includes many of the nation's largest purchasers of health care. PBGH represents both public and private purchasers who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. The members of PBGH range from large public and private purchasers such as Bank of America, CalPERS and FedEx, to thousands of small businesses in California that we serve through our small employer purchasing pool—PacAdvantage.

I welcome the opportunity to speak to you about how leading purchasers are working with consumers and providers to create market solutions for a very troubled health care system.

The Problem of Rising Hospital Costs and Quality Shortfalls

Rising hospital costs are a problem nationally, but California has been in the news recently on two fronts related to hospital pricing and the impact on consumers and purchasers. Last year, the big story was the pricing and patient selection practices for cardiac care of a Tenet hospital in Redding, California; more recently the news has been about the action of one of our members, CalPERS, to exclude some high cost hospitals from one of its HMOs offered to beneficiaries. Both stories underscore the need for change and dramatize three industry-wide issues—staggering cost increases, huge variations in the cost and quality of hospital care, and failure of the market to address these issues.

In California, hospital costs are growing at almost twice the rate of the national average. Expenditures for inpatient services in California rose at an annual rate of 11.3%[1] from 1998 to 2001, the second highest rate in the nation, almost twice the average of 5.9%[2] and nearly four times the general inflation rate of 2.9%. The picture is even worse for employers and their employees with commercial insurance—they have faced hospital cost increases of up to 20% as cost-shifting from uninsured or underfunded public programs hits employers and their employees.

- Staffing costs, especially the shortage of nurses combined with a staff ratio mandate;
- Need for investments in infrastructure and new technologies—driven in part by need for seismic retrofit, but also by a period of underinvestment in 90s;
- Increased admissions and lengths of stay;
- Hospital consolidation, which has stifled market competition; and
- Lack of transparency differentiating hospital quality and efficiency.

Why are high costs a problem? Health care consumers, our members' employees, are footing the bill, whether through increased cost-sharing, larger contributions to their employer's premium or a smaller paycheck. Hospital consolidation and the rapid acceleration of hospital cost trends not only impacts affordability, but access. Rising hospital costs drive a cycle of cost-shifting: as hospitals and doctors raise rates to recover the cost of unpaid or under-paid services. As we see cutbacks in support for public programs, the commercial market picks up a disproportionate share of hospital cost increases. Subsequent cost shifting onto premium-paying employers and consumers accelerates a vicious, self-perpetuating cycle as large employers struggle to maintain comprehensive coverage and some small employers drop coverage altogether, leading to higher rates of uninsured. Again, this is particularly true in California, where Medi-Cal—our Medicaid program—has one of the lowest reimbursement rates in the nation.

The problem is not just high cost—it is the variation in cost, and the fact that there is a total disconnect between cost and quality of care. We see variations between and within communities that defy a rational explanation and signal insufficiently competitive markets for hospital services. Gall bladder or heart surgery costs three times as much in Sacramento as in San Diego; Caesarian-section costs twice as much in Sacramento as in Los Angeles.[3]

Reasons for California's growing hospital costs include:

We also see enormous cost variations within a single community. According to data collected by the state and reported by HealthShare Technology—based on billed charges:[4]

- The average charge in Sacramento (before insurer discount) for a hysterectomy ranges from $13,921 at the lowest-charging hospital to $43,931 at the highest;
- For gall bladder surgery, from $17,826 to $61,095;
- For kidney transplant, from $115,096 to $184,183; and
- For bypass surgery, from $131,735 to $225,678.

And, there is no indication that these cost differences have any relation to different levels of quality of care. Wide cost variations reveal insufficient market competition and the gap is just as large when we look at hospital quality:

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[1] Hay, Joel. Hospital Cost Drivers: An Evaluation of State-Level Data. University of Southern California. October 15, 2002. Page 14.

[2] Ibid. Page 1.

[3] Rapaport, Lisa. Region feels pain of high hospital bills. Sacramento *Bee.* November 10, 2002.

[4] Sacramento Hospital Comparison: Full Year 2000 Inpatient Data. HealthShare Technology, Inc. November 14, 2002.

- A patient is about twice as likely to have a wound infected in the bottom 25% of hospitals as in the top 25%;[5] a similar likelihood exists for getting pneumonia after surgery and other avoidable complications;
- We now have a limited set of hospital outcomes data, such as for heart surgery, which also shows wide variation in quality;
- And we know that the extent to which hospitals have in place systems to avoid medical errors, such as having adequate intensivist coverage in intensive care units or computer physician order entry, varies dramatically and is generally insufficient.

Consumers and purchasers need—and are beginning to demand—transparent cost and quality information on individual hospitals and doctors. We want to know whose care leads to better clinical outcomes. We want to know whose care leads to how much total spending for a hospital procedure or a years' chronic illness care, and why. We need to be able to know when high hospital or physician fees enable lower total health insurance spending over an episode or year of illness and when they merely "pile on" or exacerbate higher total health insurance spending.

Solving the problem of hospital cost and quality variation will require participation by all parties. Hospitals and physicians must embrace a culture of accountability in which their payable charges, "longitudinal efficiency" with respect to total health insurance spending, and quality are transparent to consumers. Purchasers must create an environment where hospitals compete on and are paid for performance excellence.

The Market is Failing to Assure Excellence by Hospitals and Physicians

Large employers and consumer organizations agree with the Institute of Medicine's reports in 1998, 1999 and 2001 that there is a wide gap between the health care that Americans are getting and what health care could and should be. The following figure summarizes current research and expert opinion on the approximate percentage point size of the gap.

Large employers also agree with the Institute of Medicine that closing the gap requires that purchasers and insurers correct serious flaws in the market for doctor and hospital services via two actions: (1) creating precise streams of public performance measurement of doctors and hospitals; and (2) rewarding doctor and hospital excellence via *performance-based payment;* and/or *insurance plan designs* which encourage consumer selection of better performing providers.

To accelerate these two foundations of a market solution to weak health care industry performance, large American employers launched two linked "pro-competi-

[5] Kane, Nancy M. Siegrist, Richard B. Understanding Rising Hospital Inpatient Costs: Key Components of Cost and the Impact of Poor Quality. August 12, 2002. Page 30

tive" initiatives: the Consumer and Purchaser Disclosure Project ("the Disclosure Project"); and the Leapfrog Group.

The Disclosure Project is an informal partnership of *large employers, business coalitions* and *consumer advocacy and labor* that includes AARP, General Motors, Motorola, the Pacific Business Group on Health, the AFL–CIO, the Employer Health Care Alliance Cooperative ("The Alliance") in Madison, WI, the American Benefits Council, and the National Partnership for Women and Families. These groups share a commitment to health care performance accountability and the Disclosure Project's goal that *"by January 1, 2007, Americans will be able to select hospitals, physicians, integrated delivery systems and treatments based on public reporting of nationally standardized performance measures for clinical quality, patient experience, equity and efficiency."*

The Disclosure Project is promoting the National Quality Forum's (NQF) multistakeholder consensus process to define valid and feasible standardized performance measures and assure routine reporting by doctors and hospitals. If NQF-mediated progress proves insufficient, Disclosure Project members are committed to pursuing other options for performance reporting. The personal and economic consequences for consumers and purchasers of continued performance-blind selection of hospitals, doctors and treatments have become intolerable.

The Leapfrog Group is a private, non-profit organization of more than 130 of America's largest private and public employers and unions which provide over $56 billion in health benefits annually. Members commit to encouraging their employees to select, and/or their insurers to reward, better-performing hospitals, doctors, and treatment options. The "Frogs" initially focused on identifying and rewarding hospitals that excelled in three important patient safety features. The Leapfrog Group is now expanding its focus beyond patient safety and aligning its market rewards with doctor and hospital excellence across all of the performance domains advocated by the Disclosure Project.

The Disclosure Project and the Leapfrog Group are creating the national groundswell that is being translated into real first steps for both consumers and providers. I heartily recommend MedPAC's June report, which not only highlights innovative strategies undertaken by purchasers, but underscores how Medicare—like much of the private market—falls short by providing few incentives to providers or consumers; and does too little to encourage efficient delivery and organization of care.

Solutions To Reforming the Market

Purchasers look to the health plans we contract with to ensure that hospitals are not being overpaid, are being rewarded for better performance, and to provide valid tools so consumers can make better informed choices. Nationally we should have the same expectation of CMS in its administration of Medicare. And, the good news is that in recent years we have seen CMS step up to this challenge in important ways. The four elements needed to promote higher quality and more efficient care delivery in our nation's hospitals are:

1. Expand the Availability of Standardized Performance Information

We currently have a Tower of Babel of conflicting and incomplete measures to report on hospital performance. The path to resolve this problem is to support and accelerate the National Quality Forum's efforts to identify consensus performance standards. Core funding for the National Quality Forum's efforts should come from the federal government. At the same time, CMS should not only be applauded for its focus on the importance of performance transparency, but urged to accelerate its efforts to insure that useable information on hospital and physician performance gets into the hands of consumers, providers and purchasers.

The National Quality Forum has endorsed 39 measures for hospital performance, as well as a set of 30 patient safety practices. The National Quality Forum has also endorsed 15 nursing sensitive measures and 28 serious reportable events, such as wrong-site surgery. Ten of the NQF's measures of hospital performance are currently being used for the National Voluntary Hospital Reporting Initiative (currently addressing three conditions—heart failure, pneumonia and acute myocardial infarction). States are also embracing these standards—lead by Minnesota which requires all hospitals to publicly report on NQF's serious reportable events.

To move beyond the Tower of Babel we need to:

1. Rapidly adopt a standardized hospital patient experience survey and quickly get H–CAHPS into the market—building on the independent good works done by CMS and AHRQ;
2. Expand endorsed hospital measures that provide better global pictures of hospital quality, such as surgical infection rates;

3. Develop standards for measuring the relative efficiency with which care is delivered. While this hearing is titled "Hospital Pricing"—we need to get beyond looking at mere unit price, to assess the full associated health insurance costs or "longitudinal efficiency" with which care by hospitals and doctors is delivered. Such a measure would reflect not only the price charged for an admission or procedure, but also costs related to readmission, complications and post-hospital care; and
4. Make routinely available to the private sector, patient identity-encrypted version of the full Medicare claims data base, so private health plans can more precisely measure hospital and physician performance over longitudinal periods of illness (which most private sector plans do not have sufficient data with which to do on their on).

2. Reward Better Hospital Performance

There are large scale pay for performance programs that are starting to change the market by rewarding better performance of individual physicians and medical groups. The Integrated Healthcare Association's pay-for-performance initiative in California brings together seven health plans with purchasers and over two hundred medical groups—with an estimated $100 million in bonus payments based on common measures of clinical performance, patient experience and IT reengineering. Another example is the Bridges to Excellence program—a collaborative of national employers and some health plans, that uses nationally standardized certification projects from NCQA to reward better performing physicians in the areas of diabetes and cardiac care, as well as for their overall office practices.

At the hospital level, the Leapfrog Group has lead the way in identifying better performing hospitals based on valid comparative information—these Leapfrog measures are increasingly one of the core elements of health plans' efforts to include quality dimensions in hospital tiering or design of narrow networks—as has been done numerous health plans, such as Blue Shield of California, PacifiCare and Health Net.

Nationally, CMS's Premier Hospital Quality Incentive Demonstration is important both because it will reward hospitals based on their performance related to six common and expensive conditions, but also it is setting the stage for sharing with consumers information that they can and will use. The recent efforts of CMS point to a promising future if CMS continues to not only innovate and explore how best to reward higher value providers, but does so in concert with private and state-based public purchasers.

3. Provide Information and Incentives to Consumers

Across the country there is a growing array of tools being provided to health care consumers to help them make better choices. Many members of the Pacific Business Group on Health, such as Wells Fargo, the University of California and Intel, provide their employees with health plan chooser tools. These tools help consumers weigh the financial impact of their choosing a particular plan—based on their likely health care utilization—along with physician availability information, and plan quality. In addition, many employers are looking to their health plans to provide tools to help consumers choose and understand treatments.

In the hospital arena, we are using first generation tools that give consumers information on how hospitals meet Leapfrog standards and provide other information such as patient experience data, when available, or complication rates. At the same time, CMS is testing how it can best convey comparative hospital performance information to consumers. Consumers want and need this information; our task is to ensure that these tools provide valid reflections of hospitals' performance—either globally or by particular treatment.

While we develop the full dashboard of performance information—purchasers must be working today to bring together cost and quality information for their employees. We cannot pretend that all hospitals are delivery the same performance. CalPERS, a member of PBGH that is the third largest purchaser of health care in the United States, is continuing its leadership in health care by recently making the decision to exclude 38 hospitals across California from their Blue Shield HMO based on these facilities being substantially higher cost than comparable available hospitals—considering a dozen quality indicators in their determination. Through this action, CalPERS created a "virtual tiering" since beneficiaries that wanted these higher cost hospitals could still get them through their PPO—but they would pay more.

4. Allow the Market to Function

Finally, we need to be sure that comparative performance information can indeed by used to help consumers make better choices and to reward better performing hos-

pitals. There is a danger in many communities that hospital consolidation will hinder these efforts. Hospitals creating networks for their joint purchasing and negotiating is fine IF those consolidations allow the market to work. A working market means:

- Allowing individual hospitals within a network to be priced differently, whether through tiers or coinsurance. Conglomerates should not be able to prevent separate tiering by quality and efficiency;
- Conglomerates of hospitals should not be able to use their market power to prevent health plans from using their data to better define higher value hospitals;
- Conglomerates of hospitals should not be able to set one rate for all of their hospitals—different quality and cost should be able to show through; and
- Conglomerates should not be able to require inclusion of all hospitals in their network as a condition for accessing any of them.

Sadly, the examples of intensified market competition catalyzing hospital performance breakthrough remain the exception rather than the rule. For those American's fortunate enough to have health coverage, the vast majority are totally disconnected from the true costs of care and are making life and death choices with virtually no information. They have neither incentives nor information with which to make better hospital choices. Similarly, hospitals—like other health care providers—are not recognized or rewarded if they deliver higher quality care more efficiently.

We are still almost performance blind. The market's invisible hand requires standardized performance information for hospitals across the six IOM performance domains—safety, timeliness, effectiveness, efficiency, equity and patient-centeredness. The good news is that we are making progress and much of the credit for this lies with CMS' engaged commitment, demonstrated through their work with the National Voluntary Hospital Reporting Initiative; developing the national standard patient-experience survey—H–CAHPS; testing consumer presentations of quality information; and promoting pay for performance demonstrations.

Most consumers today don't have the information to make informed decisions about treatments or providers. Most providers are paid the same whether they deliver the highest quality or the lowest quality care, irrespective of their cost-effectiveness. The only solution to reforming health care over the long term is to change these two dynamics—consumers must have the information and incentives to make the best choices for them; and providers need to be rewarded for doing a better job. Thank you for the opportunity to be with you today.

Chairman HOUGHTON. Thank you, Mr. Lee.

Ms. Davis?

STATEMENT OF KAREN DAVIS, PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NEW YORK

Ms. DAVIS. Thank you, Mr. Chairman. Hospitals play a pivotal role in making health care accessible to those who cannot pay, but they also need to be financially viable. Nonprofit hospitals do charge patients less and collect lower payment rates than for-profit hospitals. I cite in my testimony a meta-analysis that summarizes all of the studies over the last 40 years, and they do conclude that net collected prices are lower in nonprofits.

Nonprofits admit more uninsured patients and they provide more uncompensated care than for-profit hospitals. Pricing uncompensated care and bill collection practices do vary widely across nonprofit hospitals, and the financial stability of hospitals also vary widely. About a third are in serious financial difficulty, a third are on the margin, and a third are doing well. Hospitals that do the best are not necessarily the most efficient or the highest quality. They are the ones providing the most uninsured care.

On the issue of price transparency, some witnesses on the panel today support it because they think it will improve cost conscious behavior by consumers. I agree that the real issue is not individual

prices, but longitudinal efficiency, as Mr. Lee has said. It is the total cost over your hospital stay, really over the episode of your illness. That is what you want to know, not how much it is per day of intensive care.

I am more skeptical than my fellow panelists about whether consumer financial incentives can really drive improved quality and efficiency performance, but I think there are other compelling rationales for transparency in health care financing and reasons why we need information on quality and efficiency. For example it would help providers improve. It is hard to improve if you don't know how you stand. It would help, as Mr. Lee says, for purchasers to financially reward hospitals, health systems, and group practices that provide higher quality care more efficiently, and I think it is important for public accountability.

Why am I skeptical about consumer-driven health care? One form of this, for example, is called tiered cost-sharing. What that means: if you are burned in a major fire, or if you have a heart attack, if you have a stroke, and you go to the wrong hospital—you don't go to the cheapest hospital or the best hospital, you go where you are taken—you can be charged $400 a day extra for every day you are in that hospital. That is not humane, and it is not going to make those hospitals higher quality or more efficient.

Having said that, I think there are solutions to trying to make care higher quality and more efficient. We can look at international examples. We can look historically at what has been tried in the United States, and the basic lesson that comes from those experiences is that government leadership matters. When government establishes a payment framework for purchasers and uses collective purchasing power to obtain better prices from providers, the rise in hospital costs is slowed, there is greater equity and there is better access to care for the uninsured.

The greatest promise for improving the performance of the health care sector lies in public information of quality and longitudinal efficiency, so I am very much for Medicare. The Federal government needs to take a leadership role and really put together the information on longitudinal efficiency over time, over the course of an illness in the following categories (by provider, by hospital, by medical group, by health system, and by private and public purchasers). As a result, Medicare, Medicaid, and private insurers have incentive payments that reward hospitals and other providers who demonstrate superior quality and efficiency. Purchasers are in a far better position to promote better quality and efficiency than are patients.

It also might be considered to set at least limits or bans on how much discounted prices can vary across payer source or patient. Certainly, it is reasonable not to charge uninsured patients more than other patients. I think it is important to preserve and strengthen a predominantly nonprofit hospital and health care sector, and think it would be reckless to undo tax preferences for nonprofit hospitals, given that they are a major source of uncompensated care and community benefit.

I think we need more creative ideas about how to create new financial incentives for the provision of charity care such as the idea of a Hill-Burton Act to provide capital funds for information tech-

nology in exchange for charitable care or better targeting of disparate proportionate share allowances. Ideally what we would have is a system of automatic and affordable health insurance coverage for all. Thank you.

[The prepared statement of Ms. Davis follows:]

Statement of Karen Davis, President, The Commonwealth Fund

EXECUTIVE SUMMARY

When a family member is seriously ill, we all expect that the benefits of modern medicine will be available to provide the finest care possible. Yet, the cracks in our fragmented health care financing system are jeopardizing the health and financial security of millions of Americans. Hospitals play a pivotal role in making care accessible to those who cannot pay, but they also need to be financially viable. It is especially important to scrutinize hospital financing and pricing practices in the current environment. Hospital costs are accelerating. At the same time, 71 million Americans are experiencing problems paying medical bills or are paying off accrued medical debt. Access to care among the uninsured and underserved in this country is threatened, and pricing practices at selected hospitals are placing vulnerable patients at financial risk. We need major reforms to improve the performance of the health care sector.

- Hospital Pricing Behavior
  - Nonprofit hospitals charge patients less than for-profit hospitals (including effective net prices after discounts).
  - Nonprofit hospitals admit more uninsured patients and provide more uncompensated care than for-profit hospitals.
  - Prices bear little relationship to the actual cost of care. Some specialized services, such as burn units and neonatal intensive care are "money losers"; others, such as cardiac surgery and radiological imaging services, are highly profitable.
  - Pricing, uncompensated care, and bill collection practices vary widely across nonprofit hospitals. The burden of caring for patients who cannot pay is unevenly borne; academic health center hospitals provide more uncompensated care than community hospitals.
  - The financial stability of hospitals varies widely. Some are in serious financial difficulty, others are on the margin, and others are doing well. Hospitals in the best position are not of the best quality or the most efficient, while those doing the worst are largely shouldering a disproportionate share of charity care.
- The Market for Hospital Services Is Different
  - Hospital care is not like consuming other goods and services.
    - Key differences include lack of information, limited choice, complexity and life-critical importance of health care treatment decisions, physicians' decision-making role, and the need for insurance to protect financial security.
    - Trying to make the market work by shifting costs to patients will inflict greater financial burdens on the sickest and most vulnerable people. Doing so does not lead to better decisions about seeking "appropriate" or "inappropriate" care and will not solve the fundamental problems of access, quality, and efficiency in the health care system.
- Consumer-Driven Health Care
  - High deductibles, cost-sharing tiering, or premium-tiering are unlikely to be effective in improving health system performance. They run the risk of increasing financial burdens on the most vulnerable patients.
  - Tiering, or varying cost-sharing according to hospitals' quality and efficiency, requires detailed information on cost and quality at the hospital or diagnostic level. For the most part, these data are not systematically available. Even were such data available and accurate, this presumes that very ill hospitalized patients are able to evaluate cost and quality tradeoffs, have a wide range of options about where to go when hospitalized, and are able to make cost-conscious choices. Furthermore, the administrative costs of such a system would be high.
- International Experience
  - The United States has much higher hospital costs than any other country. The cost per day is three times the OECD median country cost per day, and cost per capita is twice the OECD median country.

- Other countries have a greater role for government in establishing hospital budgets or payment rates. They have also done more to rationalize care through disease management, cost-effectiveness reviews of drugs and procedures, and regional hospital authorities, and have much lower administrative costs because they have one system of payment.
- The Commonwealth Fund 2003 International Health Policy Survey of hospital CEOs in five countries found that:
  - The United States is the only country where respondents cited the cost of indigent care and care for the uninsured as major problems.
  - U.S. hospitals are more concerned about stand-alone diagnostic or treatment centers and about freestanding ambulatory care centers that "cream" profitable patients.
  - U.S. hospital CEOs are less open to public reporting of quality information than CEOs in other countries.
  - Hospital CEOs in all countries would make it a high priority to invest in information technology if resources became available to do so.

- Historical Perspective on How We Got Where We Are
  - Hospital costs grew at a slower rate during the Nixon Economic Stabilization Program, legislative consideration of the Carter hospital cost-containment bill, enactment of the Medicare DRG payment system, and, during the mid-1990s, under the threat of health reform and expansion of managed care.
  - Hospital costs grew most rapidly during periods when prices were determined by health care providers rather than purchasers.
  - All-payer strategies, especially those by selected states in the 1970s and 1980s, were effective in slowing cost increases, ensuring access to care, and improving equitable payment across patients and insurance sources.
  - The basic lesson from these experiences is that government leadership matters. When government establishes a payment framework for purchasers—whether Medicare, Medicaid, or employer health plans—and uses that collective purchasing power to obtain better prices from providers, the rise in hospital costs is slowed, there is greater equity, and there is better access to care for the uninsured.
  - Large purchasers such as Medicare, national managed care plans, and large employers can also obtain good deals on their own, but they are less effective both in controlling overall cost increases and in ensuring equitable payment and access.
- Achieving a High-Performance Health Care System
  - Given the resurgence in health care costs, the increasing numbers of uninsured, abundant evidence that the quality of care is not what we could have and have a right to expect, and the fact that administrative costs are now the fastest rising component of health care expenditures, it is time to consider a leadership role for the federal government in promoting efficiency and quality in the health care system.
  - The greatest promise for improving the performance of the health care sector lies in:
    - Public information on quality and longitudinal efficiency (i.e., total cost of care over an episode of illness) of all health care providers.
    - Private and public insurance incentive payments that reward hospitals and other providers demonstrating superior quality and efficiency. Purchasers are in a far better position to promote better quality and efficiency than are individual patients.
    - Limits or bands on how much prices can vary depending on payer source. Net charges to uninsured American patients should not be higher than discounted charges to insured patients.
    - Preserving and strengthening a predominantly nonprofit hospital and health care sector. It would be reckless to undo tax preferences for nonprofit hospitals, given that they are a major source of uncompensated care and community benefit. Such hospitals may reasonably be asked not to charge uninsured patients more, to work out feasible repayment plans, and not to employ unreasonable collection tactics.
    - Investing in the capacity to adopt modern information technology and systems to ensure safe care. It might be useful to consider a new "Hill-Burton" act—perhaps one that, in exchange for a new charitable patient care obligation, provides grants and loan capital funds for investment in information technology and systems to ensure patient safety.
    - A system of automatic and affordable health insurance coverage for all.

HOSPITAL PRICING BEHAVIOR AND PATIENT FINANCIAL RISK

Karen Davis

Thank you, Mr. Chairman, for this invitation to testify on the issue of hospital pricing practices. When a family member is seriously ill, we all expect that the benefits of modern medicine will be available to provide the finest care possible. Yet, the cracks in our fragmented health care financing system are jeopardizing the health and financial security of millions of Americans. Hospitals play a pivotal role in making care accessible to those who cannot pay, but they also need to be financially viable. A strong hospital system—well equipped, professionally staffed, and ready to be of assistance in any emergency—is essential to a strong nation. To the extent that a flawed financing system undermines the financial security of the hospital sector, we are all at risk.

It is especially important to scrutinize hospital financing and pricing practices in the current environment. Hospital costs increased at an annual rate of 9.5 percent in 2002, accounting for the largest share of increases in total health expenditures.[1] Managed care has reduced the ability of hospitals to cross-subsidize care for the poor and uninsured through higher charges to privately insured patients. Hospital rates vary widely by patient and by source of insurance coverage. In fact, uninsured patients may be charged higher prices than better-off patients who are covered by private employer health insurance. In response to rising insurance premiums, employers are shifting more costs to employees, and patients are at greater financial risk.[2] A recent Commonwealth Fund survey found that 71 million American adults under age 65 are experiencing problems paying medical bills or are paying off accrued medical debt.[3] Not surprisingly, the public is very concerned about the affordability of health care.[4]

Today, I would particularly like to address current concerns about hospital pricing practices as they affect patients; review why the market for hospital care is fundamentally different from that of other goods and services; place the U.S. hospital cost experience in an international context; and provide a historical perspective on how we got where we are today. I would also be pleased to share some thoughts on issues regarding price transparency, pay-for-performance pricing, pricing guidelines, the importance of the safety net provided by nonprofit hospitals, and health care financing. In particular, the greatest promise for improving the performance of the health care sector lies in:

- public information about the quality and efficiency of all health care providers;
- private and public insurance incentive payments that reward hospitals and other providers demonstrating superior quality and efficiency;
- preserving and strengthening a predominantly nonprofit hospital and health care sector;
- investing in the capacity to adopt modern information technology and systems to ensure safe care; and
- a system of automatic and affordable health insurance coverage for all.

HOSPITAL PRICING BEHAVIOR

Thirty-five years ago, I wrote an economics doctoral dissertation on the economic behavior of nonprofit hospitals.[5] It was the first systematic examination of this issue in the newly emerging field of health economics. In my paper, I concluded that nonprofit hospitals have more complex motivations than simply providing care to the community while breaking even. Rather, these hospitals attempt to generate surpluses on some services so that they can expand, add new facilities and services, and attract practicing physicians to their staffs. In short, they want to be the best, biggest, and most well-equipped facilities possible, while remaining financially viable. For-profit hospitals, on the other hand, are more strongly motivated by profit-maximizing goals and returns to owners or investors. The resulting difference is that nonprofits are more willing to provide care that is marginally profitable or loses

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[1] K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.

[2] Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey,* September 2003.

[3] The Commonwealth Fund Biennial Health Insurance Survey (2003).

[4] Sara R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, March 2004.

[5] Karen Davis, *A Theory of Economic Behavior in Non-profit, Private Hospitals*, doctoral dissertation in economics, Rice University, May 1969.

money in order to advance a broader mission of excellence in patient care, medical education, and cutting-edge research.

In the intervening years, numerous studies have confirmed these basic conclusions. A recent meta-analysis of studies on payments for care at for-profit and private not-for-profit hospitals from the mid-1960s to the early 2000s concluded that nonprofit hospitals tend to charge less and collect lower payment rates from patients than for-profit entities do.[6] For-profit hospitals have higher profits and administrative expenses.[7] A meta-analysis has also shown that quality of care is better in nonprofit hospitals, resulting in lower risk-adjusted mortality rates.[8]

Despite the recent publicity about selected cases of nonprofit hospitals' billing and collection practices for uninsured patients,[9] it remains the case that nonprofit hospitals are more likely to care for uninsured patients than for-profit hospitals.[10] Further, academic health centers are more likely to care for such patients than community hospitals.[11] In recent years, care for the uninsured has been increasingly concentrated in fewer institutions willing to provide that care. Public academic health center hospitals provide the highest levels of charity care among all hospitals, while private nonprofit academic health centers provide twice as much free care as other private hospitals.

Also troubling is that hospital charges bear little relationship to the actual cost of care—some services are very profitable and others are not. Specialized services such as burn units and neonatal intensive care are "money losers," while cardiac surgery and radiological imaging services are highly profitable.[12] Not surprisingly, "niche providers," such as heart hospitals, orthopedic hospitals, surgical hospitals and ambulatory surgery centers (ASCs), cancer hospitals and centers, dialysis clinics, pain centers, imaging centers, and mammography centers, have been created to provide only those services that are highly profitable. This further reduces the ability of "full-service" hospitals to cross-subsidize care that is unprofitable.

In addition, managed care has made it more difficult for institutions that provide care to the uninsured to cross-subsidize uninsured care from payments for insured patients. Hospitals charge and collect very different prices for the same service depending on the source of insurance—in-network commercial insurance, out-of-network commercial insurance, negotiated contracts with different insurers and managed care plans, Medicare, or Medicaid—or the lack of any coverage. This practice might be viewed as equitable if net prices (after discounts) were systematically lower for poor patients and vulnerable elderly patients. However, uninsured patients are sometimes charged higher prices than privately insured patients, and some insurers get better breaks than others regardless of their enrollees' income.

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[6] P.J. Devereaux et al., "Payments for Care at Private For-Profit and Private Not-for-Profit Hospitals: A Systematic Review and Meta-Analysis," *Canadian Medical Association Journal*, 170(12):1817–1824, June 8, 2004.

[7] J.M. Watt et al., "The Comparative Economic Performance of Investor-Owned Chain and Not for Profit Hospitals," *New England Journal of Medicine*, 314(2):89–96, January 9, 1986.

[8] P.J. Devereaux et al., "A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-profit and Private Not-for-Profit Hospitals," *Canadian Medical Association Journal*, 166(1):1399–406, 2002.

[9] Reed Abelson and Jonathan D. Glater, "Nonprofit Hospitals Said to Overcharge Uninsured," *New York Times*, June 17, 2004; Wall Street Journal Staff Reporters, "Lawsuits Challenge Charity Hospitals on Care for Uninsured," *Wall Street Journal, June 17, 2004;* Carol Pryor et al., *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt,* The Commonwealth Fund, June 2003; Carol Pryor and Robert Seifert, *Unintended Consequences: An Update on Consumer Medical Debt,* Commonwealth Fund, June 2004.

[10] L.S. Lewin, T.J. Eckels, and L.B. Miller, "Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals," *The New England Journal of Medicine,* 1212–1215, May 5, 1988; Bradford H. Gray, "Conversion of HMOs and Hospitals: What's at Stake," *Health Affairs,* 29–47, March/April, 1997; Gary Claxton, Judith Feder, David Shactman, and Stuart Altman, "Public Policy Issues in Nonprofit Conversions: An Overview," *Health Affairs* 9–28, March/April 1997; David Shactman and Stuart H. Altman, "The Impact of Hospital Conversions on the Healthcare Safety Net," in Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields (eds.), *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* Health Administration Press; Institute of Medicine Committee on Implications of For-Profit Enterprise in Health Care, Bradford H. Gray (ed.), *For-Profit Enterprise in Health Care*, National Academy Press, 1986.

[11] Commonwealth Fund Task Force on Academic Health Centers, *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured,* Commonwealth Fund, April 2001.

[12] Commonwealth Fund Task Force on AcademicHealth Centers, Health Care at the Cutting Edge, Commonwealth Fund, July 2000.

This is one factor in the higher premiums charged for small businesses than for large businesses for the same benefits.[13]

The financial stability of hospitals also varies widely. Some are in serious financial difficulty, others are on the margin, and others are doing well. In a 2003 Commonwealth Fund survey, 30 percent of hospital CEOs reported that the current financial situation in their hospital was insufficient to maintain current levels of service; 38 percent reported it was sufficient to maintain current levels of service; and 32 percent said their financial situation allowed for some improvements or expansion of care.[14] Those hospitals in the best position are not necessarily the best-quality or most efficient ones. Instead, the hospitals that are faring worst financially are largely those shouldering a disproportionate share of charity care without adequate compensation for fulfilling this responsibility.

THE MARKET FOR HOSPITAL SERCICES IS DIFFERENT

It is easy to say patients should act like consumers, choosing among various hospitals on the basis of cost and quality. Hospital care, however, is not like other goods and services. Key differences include:

- lack of information
- lack of choice
- the complexity and life-critical importance of health care treatment decisions
- physicians' decision-making role in health care
- the need for insurance to protect financial security.

Simply stated, patients do not have the information to make informed choices in health care. Information on the total bill for a hospital stay is almost never known in advance, nor are the associated charges from physicians caring for the hospitalized patient. Even less is known about the quality of care for the condition for which the patient is being admitted.

Patients also often have little choice about where to go for care. Many communities are served by only one hospital. In emergency situations, patients may arrive by ambulance at the nearest equipped facility. For elective procedures, patients can be admitted only to hospitals where their physicians have privileges.

Decisions about care are often made at a time of great stress (e.g., heart attack, stroke, diagnosis of breast cancer, trauma). The acuity of illness of hospitalized patients has increased markedly in recent years as hospital stays have shortened and discretionary care has shifted to outpatient care. Most inpatients are very sick, and they and their families are hardly in a position to make rational economic calculations. Hospital care is not bought frequently like groceries, for which trial and error can lead consumers to find the best value for their dollars. In fact, most decisions about care are made by physicians. Doctors decide whether patients are admitted to a hospital, where they go, and what is done to them while there.

The presence of health insurance also makes the market for health care fundamentally different. Hospital care is typically covered by insurance, subject to deductible or coinsurance amounts. Protection against most of the cost of hospital care is essential to achieve one of the basic goals of insurance—to ensure financial security in the event of a serious illness or injury. Increasing how much patients have to pay out-of-pocket puts the patient at greater financial risk and may undermine the basic purpose of having insurance. Furthermore, cost-sharing for hospital care puts greater financial burdens on the sickest and most vulnerable people who have the least discretion in their use of care.

Increasing the out-of-pocket cost of hospital care is not likely to lead patients to seek care at more efficient or higher-quality hospitals. Most health care expenses are incurred above a dollar threshold exceeding most caps on out-of-pocket liability. For example, 5 percent of patients account for 55 percent of all health care outlays, and all of these patients have high total expenses (in excess of $8,000 in 1997).[15] Nearly all of these patients would exceed insurance deductibles, and most would exceed maximum out-of-pocket liability limits.

Nor are higher deductibles the answer. One-third of insured hospitalized patients with a deductible of $1,000 or more would spend more than 10 percent of their in-

[13] Jon R. Gabel and Jeremy D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Commonwealth Fund, April 2004.

[14] Robert J. Blendon et al., "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23(3):119–135, May/June 2004.

[15] A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

come out-of-pocket.[16] This is a financially burdensome exposure; it effectively leaves people underinsured.

There is growing evidence that health care is unaffordable today for many Americans, both those who are uninsured and the increasing numbers of people who are underinsured. The Commonwealth Fund Biennial Health Insurance Survey in 2003 found that two of five adults under age 65 are experiencing problems paying medical bills or have accrued medical debt.[17] Undoubtedly, hospital costs are playing a significant role. This is not just a problem for the uninsured. Among those with medical bill problems or accrued medical debt, 62 percent reported those bills were generated when they were insured. Even among people who are insured all year, over a third are experiencing medical bill problems or accrued medical debt. Raising patient cost-sharing would exacerbate the growing unaffordability of care due to already inadequate insurance protection.

CONSUMER-DRIVEN HEALTH CARE

The United States is again flirting with a "new" private market strategy for controlling health care costs called "consumer-driven" health care. This takes several forms: large-deductible insurance plans combined with health savings accounts or health reimbursement accounts; "tiered" cost-sharing, with patients paying more when they obtain care from a higher-cost hospital, physician, or other provider; or tiered premiums that let consumers pick their own package of benefits and networks of providers, with varying premiums based on comprehensiveness of benefits and costliness and/or quality of providers.

The high-deductible form of consumer driven health care is predicated on the notion that health care services are overutilized, and that giving financial incentives to patients will reduce use of services that are marginal or of no value. But the U.S. already has relatively low hospital admission rates and short length of stays compared with other countries. While there is certainly evidence of overutilization of some services, underutilization appears to be a far greater problem.[18] Patient cost-sharing, moreover, is not an effective mechanism for differentiating appropriate and inappropriate care but tends to lower use of both kinds of care.[19]

Most preferred provider organization plans (PPOs) that offer high-deductible plans also extend their negotiated rates to services received before the deductible is met. As long as patients obtain care from in-network providers, they receive the discounts that have been negotiated by their plan. Such deductibles, however, may reduce use of preventive care and may lead patients to forgo filling prescriptions for medications required to keep their conditions under control. Several recent studies, in fact, have found that tiered cost-sharing for prescription drugs has caused patients to simply not fill prescriptions written by their physicians.[20]

The real problem, though, is that the deductibles themselves add to patient financial burdens. Only about 7 percent of privately insured individuals, or 8 million adults under age 65, now have deductibles of $1,000 or more.[21] Increasing such deductibles would add considerably to medical bill problems and accrued medical debt, which already affect two of five Americans.

Consumer-driven health plans are still in their infancy and not a great deal is known about them.[22] Fewer than 3 million people were enrolled in such plans in 2003, out of more than 160 million enrollees in employer health plans. In general it appears that enrollment is relatively limited when such plans are offered as an

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[16] S. Trude, *Patient Cost Sharing: How Much is Too Much?* Center for Studying Health System Change, December 2003.

[17] Sara R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, March 2004.

[18] E.A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine,* 348(26):2635–45.

[19] K.N. Lohr et al., "Use of Medical Care in the RAND HIE," *Medical Care* 24, supplement 9:S1–87, 1986; Karen Davis, "Consumer-Directed Health Care: Will it Improve Health System Performance," *Health Services Research,* forthcoming, August 2004.

[20] R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.; H.A. Huskamp et al., "The Effect of Incentive-Based Formularies on Prescription Drug Utilization and Spending," *New England Journal of Medicine* 349(23):2224–32.

[21] Sara R. Collins et al., *The Affordability Crisis in U.S.* Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey, The Commonwealth Fund, March 2004.

[22] James C. Robinson, "Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives," *Health Affairs* Web Exclusive, W3–135–146, March 19, 2003; Jon R. Gabel, Anthony T. Lo Sasso, and Thomas Rice, "Consumer Driven Health Plans: Are They More Than Talk Now?", *Health Affairs* Web Exclusive, November 2002; J. R. Gabel, H. Whitmore, T. Rice, and A. T. Lo Sasso, "Employers' Contradictory Views About Consumer-Driven Health Care: Results of a National Study," *Health Affairs* Web Exclusive (April 21, 2004): W4–210–W4–21

option; healthier and higher-income individuals are more likely to enroll; and those who do enroll are relatively satisfied with the choice and reenrollment rates are high.[23]

Tiered cost-sharing plans are particularly problematic.[24] They require detailed information on cost and quality at the hospital or diagnostic level—data that for the most part are not systematically available. Even were such data available and accurate, this presumes that very ill hospitalized patients are able to evaluate cost and quality tradeoffs, have a wide range of options about where to go when hospitalized, and are able to make cost-conscious choices. Administrative costs would be high, as hospitals would need to vary the amount they collect from patients, depending on the particular plan in which they are enrolled. A hospital may not be equally efficient or high quality on all kinds of diagnoses or conditions, leading to the need for detailed disaggregated data on each service or kind of patient.

Tiered premiums have advantages over tiered cost-sharing in that they require decisions at the time of insurance enrollment rather than hospital admission. However, they have many of the same information requirements and would need to be structured in a way that does not penalize those who cannot afford a higher-quality, but higher-cost, provider.

INTERNATIONAL EXPERIENCE

It is not the case that high out-of-pocket spending is necessary to control health care costs. Other countries manage to spend considerably less on health care and have little or no patient cost-sharing. Nor has managed care in the U.S. provided a magic bullet to control health care spending. U.S. health expenditures over the 1990s went up the same as the average for all industrialized nations (3.1 percent annually in real terms in the U.S. vs. 3.0 percent for the median OECD country).[25] Canada and Germany had markedly slower health expenditure growth rates between 1991 and 2001 (2.1 and 2.4 percent annual real growth, respectively).

In particular, the U.S. has much higher hospital costs than any other country. But this is not because Americans get more hospital care. In fact U.S. hospital admission rates are below the average of all industrialized nations, and lengths of stay are shorter.[26] Yet, in the U.S., hospital cost per day is very high—three times the OECD median cost per day—and overall the U.S. spends twice the OECD hospital cost per capita.

The difference is that in all other countries, the government has a major role in setting hospital budgets or payment rates. Other countries also regulate the supply of hospital capacity, specialized facilities, and specialist physicians. The U.S. has more specialist physicians, and they are compensated more highly. U.S. specialist physicians are typically paid on a fee-for-service basis, whereas specialists in other countries are typically salaried under negotiated agreements and work full-time for a hospital. Other countries also have much lower administrative costs, because they have a single system of payment with a single set of rules and payment rates for all patients.[27]

Other countries also have done more to rationalize care, through disease management, cost-effectiveness reviews of drugs and specialized procedures, and regional hospital authorities.[28] This is not to say that it is desirable or feasible to adopt all of the features of other systems. Most Americans, for example, would be unwilling to accept the longer waiting times for elective procedures typical in budgeted systems. But we could learn from international innovations and benefit from that experience.

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[23] Karen Davis, "Consumer-Directed Health Care: Will it Improve Health System Performance," *Health Services Research,* forthcoming, August 2004.

[24] Robert Steinbrook, "The Cost of Admission: Tiered Copayments for Hospital Use," New England Journal of Medicine 350(25):2539–2542; Thomas M. Priselac, "The Erosion of Health Insurance: The Unintended Consequences of Tiered Products by Health Plans," Health Affairs Web Exclusive, W3–158–161, March 19, 2003; Marjorie E. Ginsburg, "Hospital Tiering: How Will it Play in Peoria," Health Affairs Web Exclusive, W3–154–157, March 19, 2003.

[25] Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "U.S. Health Spending in an International Context," *Health Affairs*, May/June 2004.

[26] Gerard F. Anderson, Varduhi Petrosyan, and Peter S. Hussey, *Multinational Comparisons of Health Systems Data, 2002: Based on Data from the Organization for Economic Cooperation and Development,* The Commonwealth Fund, October 2002.

[27] Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "U.S. Health Spending in an International Context," *Health Affairs*, May/June 2004.

[28] See for example, Reinhard Busse, "Disease Management Programs in Germany's Statutory Health Insurance System," *Health Affairs*, May/June 2004. Steven Morgan et al., "Outcomes-Based Drug Coverage in British Columbia," *Health Affairs*, May/June 2004.

It is also not the case that spending more on health care necessarily leads to higher quality care.[29] A recent international comparison of quality indicators found that quality of care is not systematically better in the U.S. The U.S. is in the mid-range on many health outcome and quality of care indicators—better than other countries on some measures, worse on others.[30] For example, five-year survival rates following kidney transplants are 13 percent better in Canada than in the U.S., while five-year survival rates for breast cancer are 14 percent better in the U.S. than in England.

A recent survey of hospital CEOs in five countries provides interesting insight into how U.S. hospitals compare with those of other countries.[31] The Commonwealth Fund 2003 International Survey of Hospital CEOs found that:

- U.S. hospital CEOs are much more negative than their counterparts in Australia, Canada, New Zealand, and the U.K. about their nation's health care system
- The U.S. is the only country where hospital CEOs cite the cost of indigent care and care for the uninsured as major problems
- U.S. hospitals are in somewhat better financial position, on average, than hospitals in other countries, but this varies across hospitals
- U.S. hospitals are more likely to experience emergency room diversions and turn patients away
- U.S. hospitals are more concerned about stand-alone diagnostic or treatment centers and freestanding ambulatory care centers "creaming" profitable patients
- U.S. hospital CEOs are less open to public reporting of quality information than CEOs in other countries
- Hospital CEOs in all countries would place a high priority on investing in information technology should resources become available to do so.

HISTORICAL PERSPECTIVE ON HOW WE GOT WHERE WE ARE

While other countries have long been comfortable with a more activist role for government in health care financing, the U.S. has had only sporadic, mostly short-lived attempts to shape the health care sector through governmental policy.[32] Instead, we have primarily relied on private markets to determine hospital prices and hospital capacity. Only for patients covered by public insurance programs—Medicare and Medicaid—has government had a major role in establishing payment rates.

Yet, the historical record of government intervention in hospital pricing, when it has happened, has been positive for the most part. The first major intervention occurred under President Nixon with the establishment of economy-wide price controls under the Economic Stabilization Program (ESP) from August 1971 to 1975. In the period prior to ESP, hospital expenses were increasing considerably faster than overall price inflation.[33] When hospitals and other providers autonomously set prices, the average real annual rate of increase in community hospital expenses from 1950 to 1965 was 8.3 percent, fueled by growth in private insurance paying hospitals on the basis of charges set by hospitals. From 1966 to 1971, real hospital expenses increased 11.6 percent annually, spurred upward by introduction of Medicare and Medicaid. Even though Medicare and Medicaid reimbursed on the basis of costs, hospitals were assured reimbursement for incurred expenses. By contrast real hospital expenses grew by "only" 6.1 percent during the ESP period. When controls were lifted, hospital costs again accelerated, averaging a real increase of 8.7 percent over 1975 to 1977.

The second attempt by the federal government was the proposed Carter Hospital Cost Containment Act, which was considered by Congress from 1977 to 1979. The legislation would have placed a limit on the rate of increase in payments to hos-

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[29] Karen Davis, et al., *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care through the Patient's Lens*, The Commonwealth Fund, January 2004.

[30] Peter S. Hussey et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs*, May/June 2004; The Commonwealth Fund International Working Group on Quality Indicators, *First Report and Recommendations of the Commonwealth Fund's International Working Group on Quality Indicators: A Report to Health Ministers of Australia, Canada, New Zealand, the United Kingdom, and the United States*, The Commonwealth Fund, June 2004.

[31] Robert Blendon et al., "Confronting Competing Demands to Improve Quality," *Health Affairs*, May/June 2004;David Blumenthal, et al., *A Five-Nation Hospital Survey: Commonalities, Differences, and Discontinuities,* The Commonwealth Fund, May 2004.

[32] Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment*, Johns Hopkins Press, 1990; Karen Davis et al., "Is Cost Containment Working?" *Health Affairs*, 4(1):81–94, Fall 1985; Drew E. Altman and Larry Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," *Health Affairs*, January 23, 2002

[33] Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment*, Johns Hopkins Press, 1990.

pitals tied to market basket inflation. But the legislation failed when the hospital industry mounted a "Voluntary Effort" to control costs. During this period, increases in hospital costs adjusted for economy-wide inflation rose 3.1 percent annually. But defeat of legislation ended the "Voluntary Effort" and hospital costs subsequently rose 7.8 percent in real terms in the 1981–1983 period.[34]

The rise of hospital costs when the threat of controls was removed—and particularly the implications for Medicare budgetary outlays—led to enactment of the Tax Equity and Fiscal Responsibility (TEFRA) legislation in 1982. TEFRA established Carter-like limits on increases in hospital payments only for Medicare. This was followed by legislation in 1983 creating the Diagnosis-Related Group (DRG) method of Medicare prospective hospital payment. Again hospital costs stabilized, increasing by 3.2 percent annually in real terms in the immediate post—Medicare PPS period (1984–86). One major effect was a sharp decline in average length of stay—undoubtedly related to the shift in Medicare payment methods from cost to a fixed rate for hospital stay.[35]

But holding down Medicare payment rates did not succeed in controlling costs to private insurers, leading to a resurgence in total spending. The Clinton Health Security Act legislation in 1993 again proposed a major role for government in controlling health care costs. In the wake of its failure, employers turned to managed care plans to ameliorate health care cost inflation. In the mid-1990s, the threat of health reform, combined with the expansion of managed care, led to a marked slow-down in health care spending, most notably in hospital care spending.[36] Managed care plans used their negotiating power to obtain discounted payment rates from hospitals, physicians, and other providers. The discounted rates reduced physician real incomes and hospital margins, but they proved to be unsustainable.[37] A pushback by providers led to a resurgence of health care costs in the early 2000s.[38]

Several state governments also stepped forward to fill the void in federal policy, particularly in the 1970s and 1980s. The most prominent of these were "all-payer rate setting" programs, particularly those in Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington. While in effect, these states experienced increases in hospital costs three to four percentage points a year lower than other states.[39] Between 1976 and 1984, the rate of increase in hospital expenses per adjusted admission was 87 percent less in rate-setting states than in non-regulated states.[40] The programs also helped stabilize hospital finances and contributed to fairly equitable payment rates across patients insured by different insurers. Many created mechanisms for explicitly cross-subsidizing hospitals providing uncompensated charity care. Yet, the anti-regulatory mood of the era led to the repeal of these efforts, with the notable exception of Maryland.

The basic lesson from this historical experience is that government leadership matters. When government establishes a payment framework for purchasers—whether Medicare, Medicaid, employer health plans—and uses that collective purchasing power to set or negotiate prices from providers, the rise in hospital costs is slowed, there is greater equity by income of patients and across different sources of coverage, and better access to care for the uninsured. Large purchasers—Medicare, national managed care plans, large employers—can also obtain good deals on their own, but they are less effective both in controlling overall cost increases and in ensuring equitable payment and access. A fragmented financing system, with each payer setting its own rules, also inflicts a toll in the form of higher administrative costs. On the flip side, if purchasers join together to exact steep discounts, this

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[34] Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment*, Johns Hopkins Press, 1990; Karen Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort," testimony before U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, hearing on "Increase in Hospital Costs: Is the Voluntary Effort Working?" December 15, 1981.

[35] Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment*, Johns Hopkins Press, 1990.

[36] Drew E. Altman and Larry Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," *Health Affairs*, January 23, 2002

[37] Karen Davis and Barbara S. Cooper, *American Health Care: Why So Costly?* Testimony for the Senate Appropriations Subcommittee, June 2003.

[38] Karen Davis and Barbara S. Cooper, *American Health Care: Why So Costly?* Testimony for the Senate Appropriations Subcommittee, June 2003

[39] Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment*, Johns Hopkins Press, 1990; Karen Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort," testimony before U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, hearing on "Increase in Hospital Costs: Is the Voluntary Effort Working?" December 15, 1981.

[40] Carl J. Schramm, Steven C. Renn, and Brian Biles, "Controlling Hospital Cost Inflation: New Perspectives on State Rate Setting," *Health Affairs*, 5:22-33, Fall 1986.

system may undermine the financial stability of the hospital sector, dampen investment in innovation such as information technology, and undermine important social missions, including the promotion of cutting-edge research, education, and excellence in patient care.

PUBLIC POLICY OPTIONS

Given the resurgence in health care costs, the increasing numbers of uninsured, abundant evidence that the quality of care is not what we could have and have a right to expect, and the fact that administrative costs are now the fastest rising component of health care expenditures, it is time to consider a leadership role for the federal government in promoting efficiency and quality in the health care system.[41] Many health care market participants are now willing to consider strong governmental intervention to repair the health care system.[42] Neither the market reforms of the last two decades nor consumer-driven health care provide the needed impetus for fundamental change in the quality and efficiency in the U.S. health care system.

My own view is that the greatest promise lies in a combination of improved information on quality and efficiency, pay-for-performance purchasing by private and public insurers, and investment in the capacity to modernize the health care system. Most fundamentally, we need a streamlined, automatic health insurance system that ensures all Americans have access to affordable health care.

Price Transparency

It is hard to improve if you have no idea how you are performing or the results that others are achieving. While I am skeptical about the ability of consumer financial incentives to bring about fundamental change in health care, I do think that information on quality and efficiency at the individual provider level is absolutely essential if health care organizations are to improve their performance.

What is needed is not so much information on prices of individual hospital or physician services—which are often meaningless—but information on the total cost of care over an episode of illness or period of time. If a patient goes to a hospital where he or she will be seen by 10 different physicians and spend a long time in the intensive care unit, it is the total bill for hospital, physician, and other services that is of concern to the patient, not the daily room rate or the charge for a day of intensive care. Further, if a hospital discharges a patient quickly but fails to help the patient learn effective self-care techniques, the patient may be quickly readmitted. So it is not the price per service or the total hospital bill for a stay that is relevant, but the total charges for all services over a period of time for the kind of condition and complexity faced by the patient.

John Wennberg and colleagues recently demonstrated that use of hospitals, intensive care days, physician visits, number of physicians involved in care, and use of hospice care in the last six months of life varied widely for the 77 leading U.S. hospitals.[43] Days in hospital per decedent ranged from 9.4 to 27.1; days in intensive care ranged from 1.6 to 9.5; number of physician visits ranged from 17.6 to 76.2; percentage of patients seeing 10 or more physicians ranged from 16.9 percent to 58.5 percent, and hospice enrollment ranged from 10.8 percent to 43.8 percent. In short, it is "practice style" that leads to wide variations in the use of health care resources. Patients have almost no ability to know how they will be treated, what services they will need, or what the total bills will be when they experience a life-threatening condition. Generating information on provider "longitudinal efficiency"—that is, the total cost of care over an episode of illness or over a period of time—could begin to shed light on "best practices and lead hospitals to emulate the practices of high-performing organizations.

But efficiency is not the only important dimension. Quality is equally important. Steven Grossbart at Premier, Inc., recently demonstrated wide variation in both cost

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[41] Karen Davis, "Achieving a High Performance Health System," *Commonwealth Fund 2003 Annual Report*, January 2004; Stephen C. Schoenbaum, Anne-Marie J. Audet, and Karen Davis, "Obtaining Greater Value from Health Care: The Roles of the U.S. Government," *Health Affairs*, November 2003; Karen Davis, Cathy Schoen, and Steve Schoenbaum, "A 2020 Vision for American Health Care." *Archives of Internal Medicine,* December 2000.

[42] Len M. Nichols et al., "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning," *Health Affairs* 23(3):8–21, March/April 2004.

[43] John E. Wennberg et al., "Use of Hospitals, Physician Visits, and Hospice Care During Last Six Months of Life Among Cohorts Loyal to Highly Respected Hospitals in the United States," *British Medical Journal* 328:607:1–5, March 13, 2004.

and quality across Premier hospitals.[44] For example, he found a five-fold variation in poor outcomes adjusted for complexity for coronary artery bypass graft, and a two-fold variation in cost per case, similarly adjusted for case-mix complexity.

One of the difficulties with generating this information is the absence of a multi-payer claims data base with unique provider identification. One important step would be for Medicare to lead in forging a collaboration among Medicare, Medicaid, and private insurers to assemble such a multi-payer claims database and make it widely available to researchers and providers. After improving the accuracy and validity of the data, public information on provideuld be a very strong motivator for improvement. A thoughtful middle ground has been proposed that would:

- engage providers as "coauthors" working to improve the quality of the tools and to ensure that appropriate caveats about weaknesses in the analyses are on prominent display;
- include a multidimensional approach to reporting on quality to help ensure that various dimensions and attributes are considered;
- not tying consumer copayments to tiers;including both quality and cost in financial rewards for providers;
- transparency to purchasers, providers, and patients;physician data aggregated at the physician group level; and
- collaboration among payers, purchasers, patients, and providers in development of systems of public accountability.[45]

Pay for Performance

The natural desire of physicians and other health care leaders to provide high-quality care may be adequate to stimulate improvement once such a database is created. However, it would also be important for purchasers (Medicare, Medicaid, private insurers) to reward high performance hospitals that demonstrate better quality and efficiency, as well as high-performance integrated health systems and accountable physician group practices. Purchasers are in a far better position to promote better quality and efficiency than are individual patients.

There are more than 75 pay-for-performance programs across the U.S. including those that are provider-driven (e.g., Pacificare), insurance driven (Blue Cross/Blue Shield in Massachusetts), and employer driven (Bridges to Excellence).[46] The new Medicare Modernization Act also calls for demonstrations to provide bonuses to physicians on a per-beneficiary basis when quality standards are met. Several states have built performance-based incentives into Medicaid contracts, including Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin.

The U.K.'s new contract with general practitioners also includes bonuses pegged to quality performance.[47] Up to 18 percent of physician practice earnings will be at risk. Physicians were heavily involved in selecting the 146 performance measures.

Pricing Guidelines

The current system of hospital pricing is clearly inequitable and administratively inefficient. A major effort should be mounted to identify ways of reducing providers' administrative costs and simplifying payer rules and pricing practices.

It will also be important to address in some way the wide disparities in prices faced by different sets of patients. It would be reasonable to consider limits or bands on how much prices can vary depending on payer source (perhaps pegged to a percentage of Medicare DRG payment rate). Given urgent concerns about the financial burdens on uninsured and low-income underinsured Americans, net charges (after discounts) to such patients certainly should not be higher than those charged insured patients.

We should also remember that all-payer rate-setting worked well in the past. It was much simpler administratively than our current system, much more equitable, and more effective in controlling costs. It may need to be revisited if upward cost pressures and financial instability in the hospital sector persist.

Preserving and Strengthening the Safety Net

In the current environment, nonprofit hospitals that provide uncompensated care to the uninsured and fulfill other vital social missions should be preserved and

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[44] S. Grossbart, Ph.D., Director, Healthcare Informatics, Premier, Inc., The Business Case for Safety and Quality: What Can Our Databases Tell Us," Fifth Annual National Patient Safety Foundation Patient Safety Congress, March 15, 2003.

[45] Thomas H. Lee, Gregg S. Meyer, and Troyen A. Brennan, "A Middle Ground on Public Accountability," *New England Journal of Medicine* 350:23:2409–2412, June 3, 2004.

[46] Leapfrog Group, draft report to The Commonwealth Fund, 2004.

[47] Peter Smith and Nick York, "Quality Incentives: The Case of U.K. General Practitioners," *Health Affairs* May/June 2004.

strengthened. It would be reckless to undo tax preferences for nonprofit hospitals. They are a major source of uncompensated care and community benefit. The current community benefits standard is broader than just charity care—some hospitals make a contribution through provision of high-cost "unprofitable" services such as burn care and trauma care; others make a contribution through medical education and training health professionals.

It may be reasonable to refine expectations about what nonprofit hospitals should contribute to their community. It is reasonable to ask that the uninsured not be charged more than other patients, and that hospitals work out feasible repayment plans and not employ unreasonable collection tactics. Certainly if there is a major emergency, whether a fire in a nightclub or a terrorist attack, we want hospitals to open their doors to all victims regardless of their ability to pay.

At one time, hospitals had an obligation to provide charity care in exchange for grant and loan capital funds received in the past. It might be useful to consider a new "Hill-Burton" act, perhaps one that, in exchange for providing charitable care, would make available grants and loan capital funds for investment in information technology and systems to enhance patient safety.

Alternatively, the disproportionate share allowance for hospitals could be better targeted, for example, providing payments at some percentage of the Medicare DRG payment rate for each uninsured patient served. Some portion might be specified for investment in modern information technology or systems to prevent medical errors.

These measures are not just important in the short term. Even as we move to improve insurance coverage, it is important to preserve the safety net to ensure that health care is open to those who are difficult to insure—immigrants, the homeless, the mentally ill—and that all patients can receive patient-centered, culturally competent care.

We also need to ensure that our nation's academic health centers are able to continue their vital social missions of investing in cutting-edge research, providing specialized care that may not be profitable but is nonetheless valued by society, and training new generations of medical leaders and health professionals.

Insurance Coverage and Access to Care for Vulnerable Populations

We will never have an efficient and equitable system so long as millions of Americans go without health insurance coverage. Over 85 million Americans are uninsured at some point over a four-year period,[48] and millions more are underinsured. Two of five Americans are struggling with medical bill problems or paying off medical debts. Tinkering with hospital prices and cost-sharing will do little to solve this problem. A bolder strategy is urgently needed. Fundamental reform requires automatic and affordable insurance coverage for all. Thank you for the opportunity to be here today.

[48] Pamela Farley Short, Deborah R. Graefe, and Cathy Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America 's Uninsured Problem,* The Commonwealth Fund, November 2003.

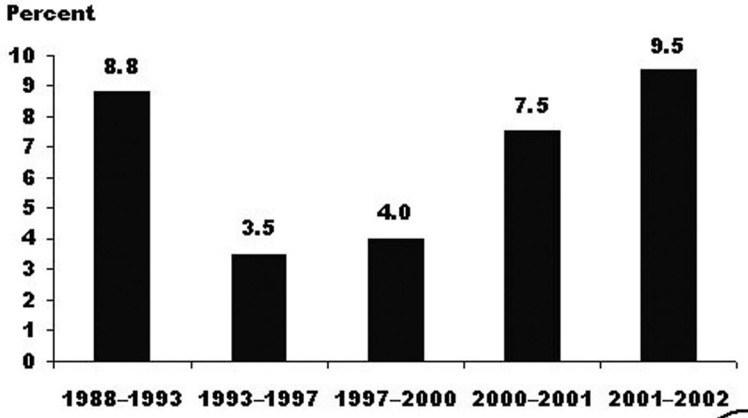
Hospital Pricing and Patient Financial Risk

Karen Davis
President, The Commonwealth Fund
June 22, 2004

Hearing on Pricing Practices of Hospitals
Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives

1

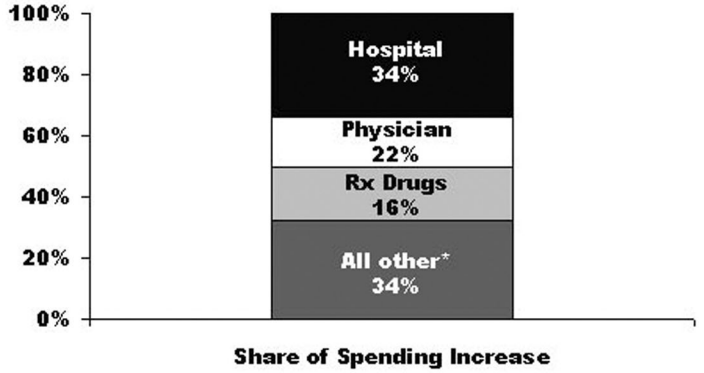
Average Annual Growth in Hospital Costs, 1988–2002



Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.

2

Hospital Costs Are a Major New Source of Increased Outlays, 2002

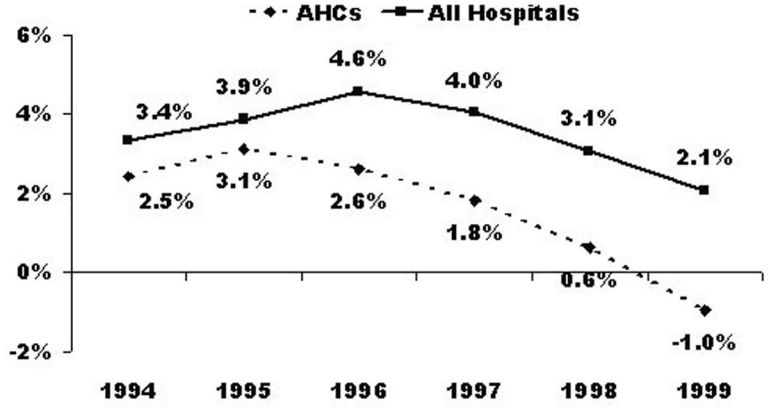


* Includes spending for dental, other professional, and other personal health care services; home health and nursing home care; durable and other nondurable medical products; administration and insurance net cost; government public health; medical research; and medical construction.

Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.

3

Trends in Operating Margins of All Hospitals and Academic Health Centers, 1994–1999

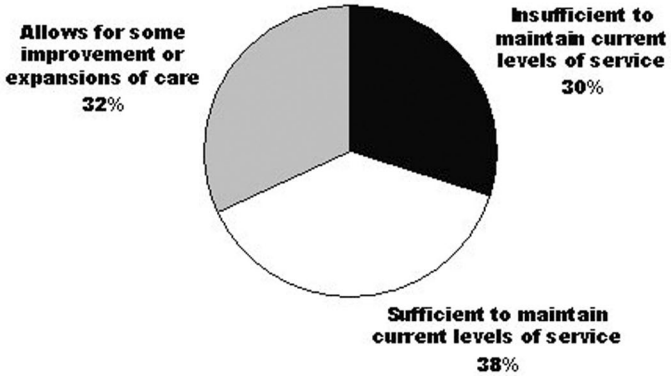


Note: Operating Margin = (Net revenue - Non-operating Revenue - Hospital Expense)/(Net Revenue - Non-Operating Revenue). AHC includes reported community hospitals data only; Total includes reported and imputed community hospital data only.

Source: Commonwealth Fund; Report by Allen Dobson, Lane Koenig, Namrata Sen, Silver Ho, Lewin Group, Analysis of AHA Annual Survey data.

4

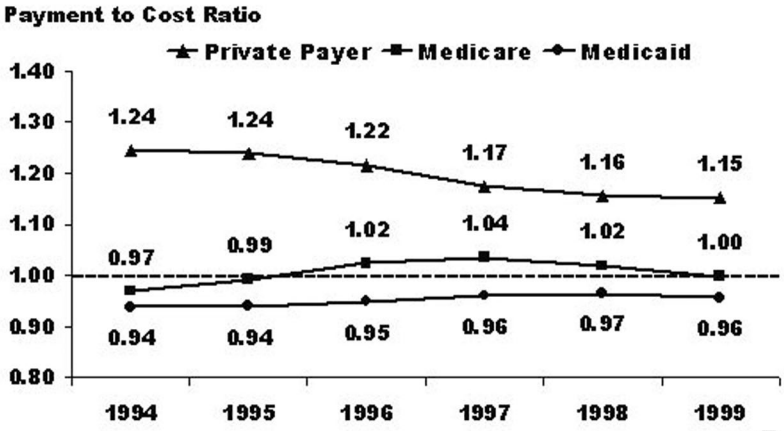
Current Financial Situation of U.S. Hospitals



Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital CEOs.

5

Trends in Payment to Cost Ratios by Payer for All U.S. Hospitals, 1994–1999

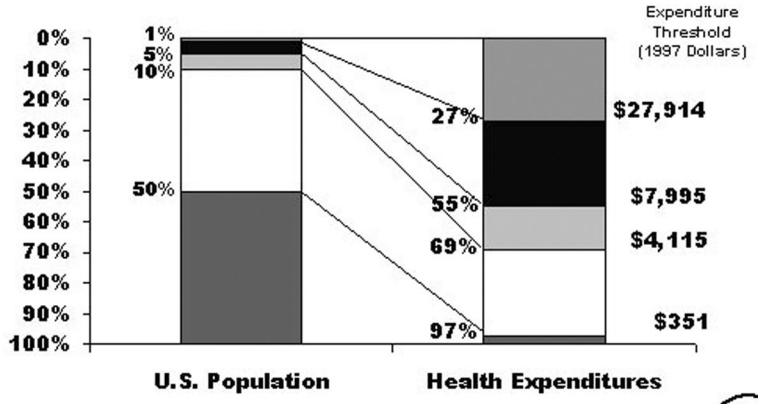


Note: Includes reported community hospital data only.
Source: Commonwealth Fund; Report by Allen Dobson, Lane Koenig, Namrata Sen, Silver Ho, Lewin Group, Analysis of AHA Annual Survey data.

6

Health Care Costs Concentrated in Sick Few

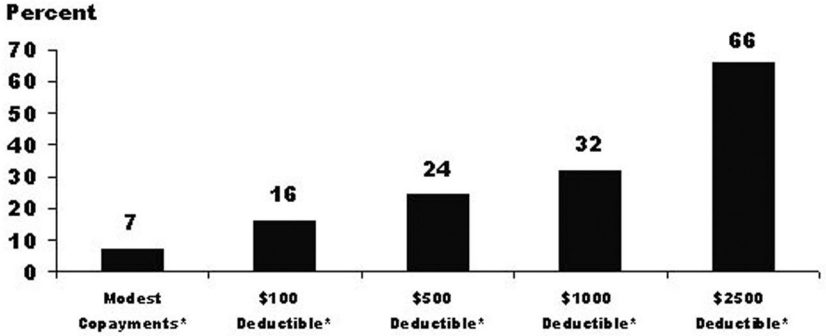
Distribution of Health Expenditures for the U.S. Population, By Magnitude of Expenditure, 1997



Source: A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

7

Percent of Hospitalized Patients with Out-of-Pocket Costs Exceeding 10% of Income by Cost-Sharing Amount



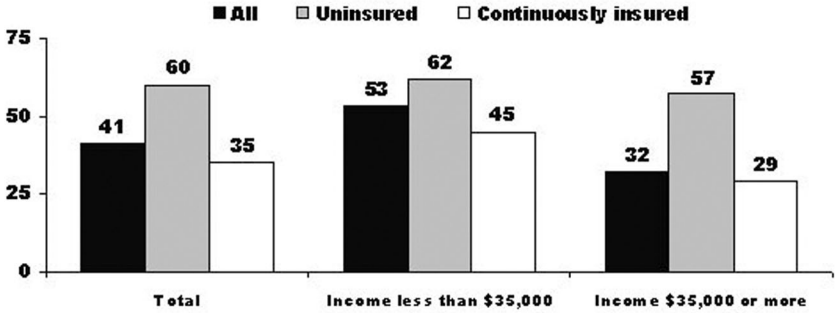
* Notes:
Modest Co-payments Option has $20 co-pay for physician visits, $150 co-pay for ED visits, and $250 co-pay per day inpatient hospitalization; $100 Deductible Option has 10% in-network coinsurance and 20% out-of-network coinsurance; $500 Deductible Option has 20% in-network coinsurance and 30% out-of-network coinsurance; $1000 Deductible Option has 20% in-network coinsurance and 30% out-of-network coinsurance; $2500 Deductible Option also 30% in-network coinsurance, 50% out-of-network coinsurance; Maximum out-of-pocket limits are set at $1,500 more than deductible for all options.

Source: S. Trude, *Patient Cost Sharing: How Much is Too Much?* Center for Studying Health System Change, December 2003.

8

Two of Five Adults Have Medical Bill Problems or Accrued Medical Debt:* Uninsured and Low Income Most at Risk

Percent of adults ages 19–64 with any medical bill problem or outstanding debt



* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

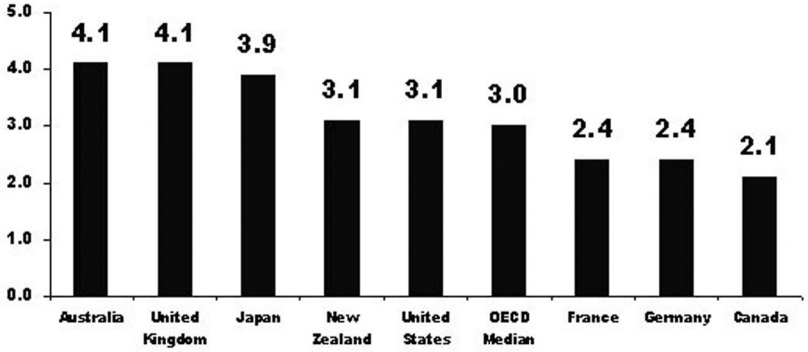
Note: Income groups based on 2002 household income.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

9

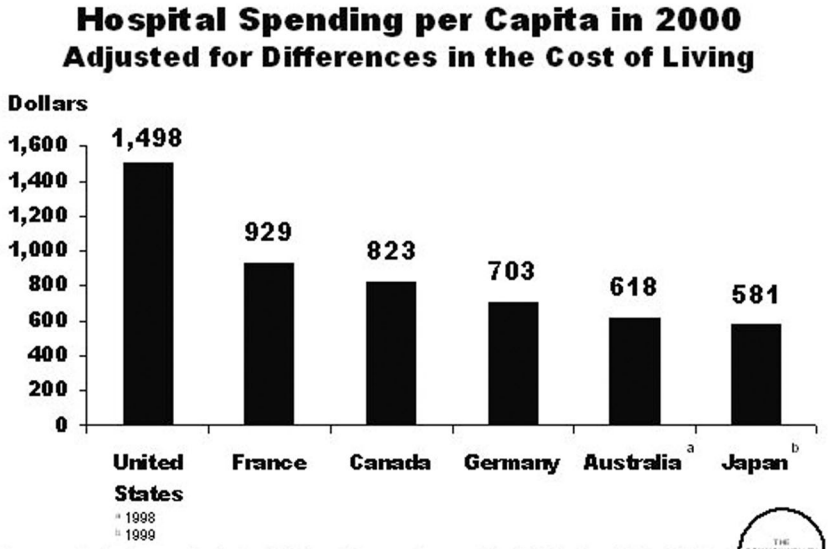
Average Annual Growth Rate of Total Health Care Spending per Capita Between 1991 and 2001 in Selected Countries

Percent



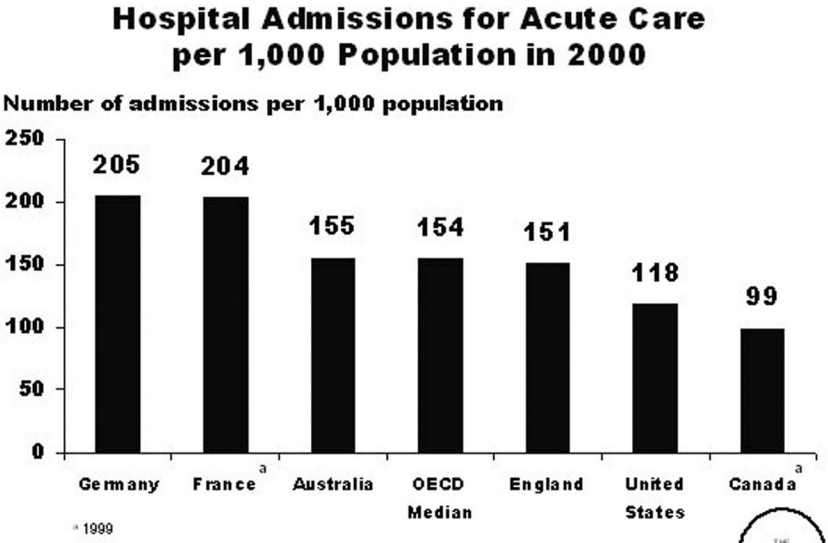
Source: U.E. Reinhardt, P.S. Hussey, and G.F. Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* (May/June 2004): 10–25.

10



Source: G. Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002.

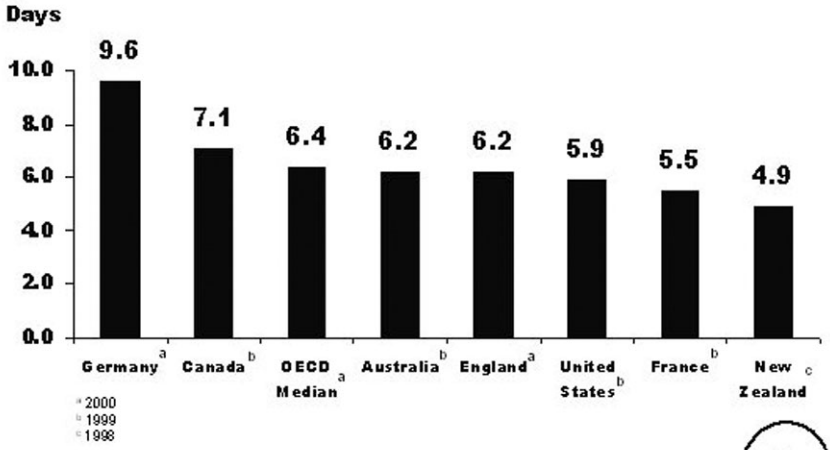
11



Source: G. Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002.

12

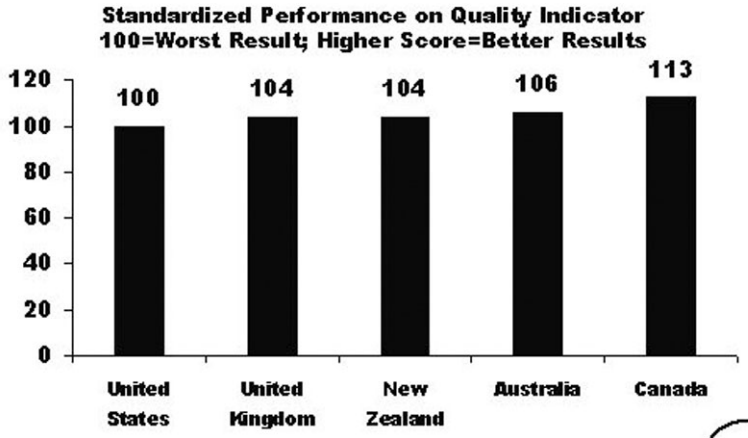
Average Length of Hospital Stay for Acute Care



Source: G. Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002.

13

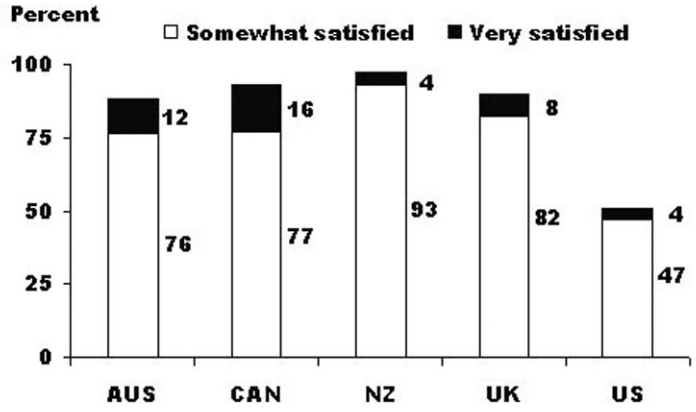
Kidney Transplant Five-Year Relative Survival Rate



Source: P.S. Hussey et al., "How Does the Quality of Medical Care Compare in Five Countries?" *Health Affairs,* May/June 2004.

14

Satisfaction with the Health Care System



Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital CEOs.

15

Disclosing Hospital Quality Information to the Public: Views of Hospital CEOs in Five Nations

Percent saying should NOT be released to the public:	AUS	CAN	NZ	UK	US
Mortality rates for specific conditions	34%	26%	18%	16%	31%
Frequency of specific procedures	16	5	4	13	15
Medical error rate	31	18	25	15	40
Patient satisfaction ratings	5	2	0	1	17
Average waiting times for elective procedures	6	1	0	1	29
Nosocomial infection rates	25	10	25	9	29

Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital CEOs.

16

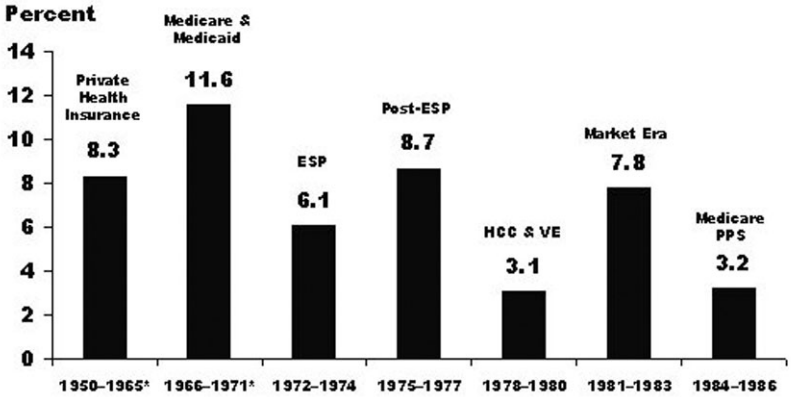
If You Had New Funding to Invest in a One-Time Capital Improvement to Improve Quality of Patient Care in One Area of Your Hospital, What Would it Be?

Percent saying:	AUS	CAN	NZ	UK	US
Electronic medical records/IT	35%	47%	46%	38%	62%
Emergency room/OR/Critical care facility	26	18	4	22	13
Basic hospital/patient facilities	17	14	21	22	3
Diagnostic equipment/medical technology	9	16	11	10	3

Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital CEOs.

17

Average Annual Rate of Increase in Real Community Hospital Expenses, 1950–1986



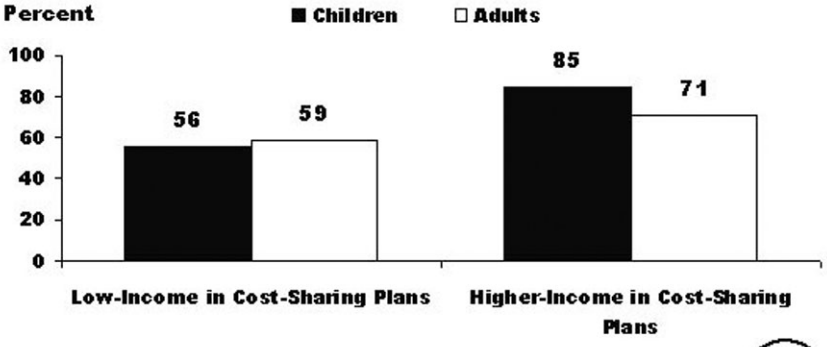
* Annualized.

Source: K. Davis et al., *Health Care Cost Containment,* Baltimore: Johns Hopkins University Press, 1990, p. 171.

18

Cost-Sharing Reduces Likelihood of Receiving Effective Medical Care

Probability of receiving highly effective care for acute conditions that is appropriate and necessary compared to those with no cost-sharing

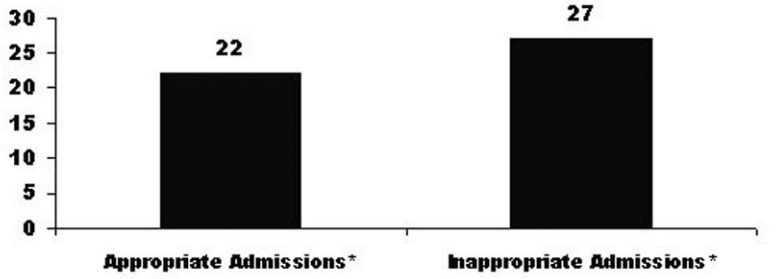


Source: K.N. Lohr et al., Use of Medical Care in the RAND HIE. *Medical Care* 24, supplement 9 (1986): S1-87.

19

Cost-Sharing Reduces Both Appropriate and Inappropriate Hospital Admissions

Percent reduction in number of hospital admissions per 1,000 person-years



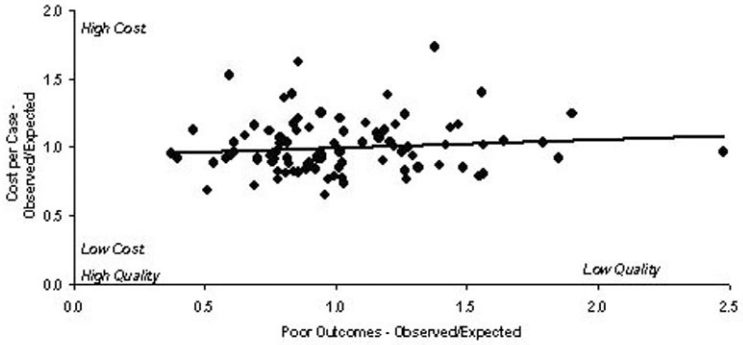
*** Based on Appropriateness Evaluation Protocol (AEP) instrument developed by Boston University researchers in consultation with Massachusetts physicians**

Source: A.L. Siu et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," *New England Journal of Medicine* 315, no. 20 (1986): 1259–1266.

20

Cost and Quality Vary Widely Across Hospitals

Coronary Artery Bypass Graft:
Observed/Expected Cost vs. Observed/Expected Quality Outcomes
by Hospital



Source: S. Grossbart, Ph.D., Director, Healthcare Informatics, Premier, Inc., "The Business Case for Safety and Quality: What Can Our Databases Tell Us," 5th Annual NPSF Patient Safety Congress, March 15, 2003.

21

Pay for Performance Programs

- **There are over 75 pay-for-performance programs across the U.S.**
  - **Provider driven (e.g., Pacificare)**
  - **Insurance driven (e.g., BC/BS in MA)**
  - **Employer driven (e.g., Bridges to Excellence—Verizon, GE, Ford, Humana, P&G, and UPS)**
  - **Medicare**
    - **2003 Medicare Rx legislation demonstrations of Medicare physicians a per-beneficiary bonus if specified quality standards are met**
  - **Medicaid**
    - **RIte Care will pay about 1% bonus on its capitation rate to plans meeting 21 specified performance goals**
    - **4 other states built performance-based incentives into Medicaid contracts—UT, WI, IO, MA**
- **Evaluation of impact still pending**

Source: Leapfrog report, draft for Commonwealth Fund.

Chairman HOUGHTON. Thanks very much. Dr. Herzlinger.

STATEMENT OF REGINA E. HERZLINGER, NANCY R. MCPHERSON PROFESSOR, HARVARD BUSINESS SCHOOL, BOSTON, MASSACHUSETTS

Ms. HERZLINGER. Thank you so much. I am honored to be here. It is very nice to see you again, Chairman Houghton. I last saw you at the 2000 Harvard Army Reserve Officer Training Corps induction ceremonies, and you gave a very moving and eloquent speech there, and my son, Captain Alexander Herzlinger, is now with the 101st Mountain Division in Iraq.

I would like to talk about how we get to this position. In most of our economy prices continually go down, quality continually goes up, and people have good access, so whether you are Jane Doe or a Member of this Committee, the elite of the United States, you have the same kind of access.

Why don't we look at those sectors and compare them to health care and see what they have that health care does not? Let's look at the automobile sector where prices have gone down, quality has gone up, and even poor people can buy very good automobiles. What happened?

First of all, consumers are in charge so the market is tailored to them and not to intermediaries like insurers. Second, providers are free to price as they want. Right now, for example, it is a good time to buy an Impala because the Chevrolet company has over produced its Impalas and it is cutting the prices. Thirdly, those markets have terrific information, so even though Congressman Stark may have ease in buying an automobile, I find it terribly complicated, but I have great information about the quality of cars that comes from sources like Consumer Reports and J.D. Power.

What happens when we have this kind of consumer-led system in health care? There are great things for the uninsured. For example, there is a company called Health Allies, which is a subdivision of United, which is the largest health insurer in the United States. Health Allies offers insurance from $500 to $3,000 for the uninsured, and the insurance is very good insurance. It is called essential coverage, and Health Allies negotiates on behalf of its individual members, and it gives them the market power that big insurers bring to their enrollees.

Congressman Stark asked why there were no data on prices. In fact, getting the price of a hospital procedure is akin to getting the battle plan for Iraq, it is very difficult right now, but there are private sector companies like Ingenix that make such data available. It is again a subdivision of UnitedHealthcare.

So, what is the role of government in solving the problem, the terrible problem that people who lack health insurance face when they enter hospitals? I think it is to enable a consumer-driven system that makes it possible for everybody to be on the same footing. Through the leadership of Congressman Thomas and Congresswoman Johnson, we have gotten HSAs and tax credits. Those are huge benefits for uninsured people, and give them tax support to buy health insurance. The providers must be free to price just like other providers in the United States are free to price, and the micro-management that we now have of provider pricing can't be anything but harmful.

The third and most important is to shed some sunlight in this market. A very good model is the Securities and Exchange Commission. When President Franklin Delano Roosevelt was elected President there was no transparency in the capital markets. There were no annual reports. There was no information that shareholders had. President Franklin Delano Roosevelt was urged, like you are, by various Members of this Committee, to regulate the business community more closely. He very wisely and presciently demurred, and what he chose to do was foster the Securities and Exchange Commission Act, and he said, approximately, "Sunshine is the best disinfectant."

What does the Securities and Exchange Commission do? It has fostered the lauded transparency and efficiency of our capital markets. It does not dictate what is to be measured. It does, however, require disclosure and dissemination of data. I hope and urge you that this model is followed in health care because sunshine is the best healer.

[The prepared statement of Ms. Herzlinger follows:]

Statement of Regina E. Herzlinger,* Nancy R. McPherson Professor, Harvard Business School, Boston, Massachusetts

Consumer-driven markets succeed when good price and quality information is available. Consumers reward those who provide good values for the money and penalize the others.

Thus, when, in the 1970s, *Consumer Reports* began its favorable ratings of Japanese cars, the American manufacturers controlled 90% plus of the market. By 2003, Japanese cars, which continued to dominate the best-value-for-the-money ratings, had a 35% market share. But the Americans improved. By 2000, U.S. cars equaled European ones in reliability. The Japanese cars had only a small edge. Quite a change from 1980, when U.S. cars were three times as unreliable as Japanese ones and twice as unreliable as European vehicles.[1]

Last, automobile prices are currently the lowest in two decades. In 1991, for example, the average family required 30 weeks of income for the purchase of a new vehicle; but by 1999, a new vehicle required only 24 weeks of their income—a 20% decline.[2] Simultaneously, automobile quality is at an all-time high. The range of choices is better too, as the quality differences between the best and worst manufactures have declined.

Why does the car market work so well—increasing quality, widespread ownership, decreasing price—in contrast to the health care markets, whose cost increases substantially outstrip income; whose quality is unknown; and where the uninsured pay much higher prices than others?

1. *Consumers are the buyers.*
2. *Manufacturers can freely vary prices* in response to changes in their production and sales. For example, they currently are slashing the prices of cars with large inventories, such as the Impala.
3. *Consumers have access to excellent information on both prices and quality* from private sector organizations, such as *Consumer Reports* and J.D. Power.

All of these attributes are missing in the hospital market:

1. The hospitals sell mostly to third-party insurers, not to individual consumers. As a result, consumers lack market power. In 2000, more than 90% of expenditures for hospitals came from third-party payers.
2. Hospitals cannot vary their prices to these third parties as a result of changing market conditions during the course of the year. Because prices are determined

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[1] "Twenty Years of *Consumer Reports* Surveys Show Astounding Gains," *Consumer Reports,* April 2000, p. 12.

[2] Auto Affordability Index, accessed August 21, 2003.

annually, hospitals cannot cut their prices during periods of low occupancy to attract patients who need nonemergency services.

Further, because many of the third-party insurers demand discounts off list prices, hospitals raise the prices to convince the insurers that they are receiving substantial discounts. For this reason, hospital charges have risen three times faster than their costs from 1995–2002. These list prices are then typically charged to individual uninsured consumers who lack market power.

3. Price information is very difficult to obtain and quality data are virtually nonexistent.

The Solution to Price Gouging of the Uninsured

To help the individual, uninsured hospital customer to be as capable of receiving good value for the money as a car buyer requires replicating its essential characteristics in the health care sector.

1. *Consumers buy insurance for themselves* in an individual market. Tax-credits and HSAs are critical to this transformation.
2. *Providers are free to quote their own prices* and to change them as circumstances vary in the individual market.
3. *Information on health care prices and quality* is freely available.

Band-Aid solutions to Price-Gouging of the Uninsured

Other well-intended solutions to the problems of the uninsured are unlikely to be as effective as a consumer-driven health care system.

Transparency—Many would require hospitals to post price information prominently. But what use is information in the absence of consumers' market power?

Charity Care Reminders—Others would require hospitals to inform uninsured patients that charity care is available. The proposal creates nightmarish auditing requirements and does not help the uninsured who are not poor enough to qualify for charity care.

Rate Setting—Yet others would extend governmental power to setting all hospital prices. This proposal extends the present micromanagement and further limits productivity-enhancing innovations.

How Consumer-Driven Markets Work

How do consumers cause products to be better and cheaper? After all, the average person is not an expert about most purchases and represents only one buyer.

One reason that average people can reshape whole industries is that markets are guided not by the average consumer, but by the marginal one. In English, this economic jargon means that producers respond to their *last* customers, not to their *average* customer. Typically the last ones to buy drive the toughest bargain; they are the show-me crowd. These hard-nosed buyers are the heavy consumers of information who are most adept in interpreting and using it. Below I will illustrate this mechanism in the automobile and finance sectors.

The Automobile Sector

To understand how this market mechanism works, consider my purchase of a car. I confess: I have only the dimmest notion of how a car functions. After all, a car is a high-tech device, studded with microchips. My notions of the mechanical compression and ignition of gasoline that lead to an explosion whose energy ultimately rotates the wheels of a car are as dated as my first car, the 1957 Dodge that I purchased in 1966. It got seven miles to the gallon, rivaled a stretch limo in length, and belched pollutants.

I do not think that I am alone in my ignorance. When I see someone in an automobile showroom peering under the hood of a car, I think to myself, "What the heck are you looking at?" Nevertheless, like all Americans, I can now readily find the kind of car I want at a price I am willing to pay. Two ingredients are crucial.

One is information. It enables me to be an intelligent car shopper, despite my ignorance.

How does it work? It's simple. I review the rating literature to look for a car that embodies the attributes I seek: safety, reliability, and price. Thus, when I studied *Consumer Reports* for cars with these attributes, two brands caught my eye: Volvo and Buick. I confess. I skipped the earnest reviews of how the engines work, the fuel-efficiency, the comfort, the handling, the styling, etc. Safety, reliability, and price—that is what interests me. And objective information about the attributes in which I am interested is easily available to me.

I opted for the Buick. Although it was not as reliable as the Volvo, it was cheaper and had more of the heft that I associate with safety.

But many of those who shared my views of a car's desired characteristics opted for the Volvo. It grew from being an obscure Swedish brand to a substantial one with sales of 100,000 cars in 2001.[3] During this growth period, Volvo's rivals understood that a meaningful number of their customers were interested in safety and reliability and introduced these qualities into their cars. In the quest for safety, some of them acquired rival brands, such as Ford's 1999 acquisition of Volvo.[4] Other automobile manufacturers improved their reliability.[5]

So that is how cars became better even when the consumer is a doofus like me. Information makes dumb people like me smart.

But what stops the car manufacturers from refusing to cut their prices?

After all, I am only one person.

At a high price, there are only a few buyers who are more-or-less indifferent to price. The good news is that they are willing to buy at a very high price. The bad news is that there are only a few of them. As providers reduced their prices, they attract more and more customers. The increased volume of customers more than compensates for the cut in price. Providers continue to reduce their price until they hit a brick wall: the last picky, tough-minded customers who set the price. At this price, the extra revenue the providers generate from sales to the hard-bargain drivers is roughly equal to the extra cost of manufacturing their purchases. All the rest of us benefit from the assertiveness of the last-to-buy crowd.

This relatively small group of demanding consumers seek out the suppliers who will reduce price and improve quality. For example, a McKinsey study showed that a small group, only 100 investors, "significantly affect the share prices of most large companies."[6]

In the auto market, and most others, these three characteristics—information, a group of picky consumers, and the ability of manufacturers to quote prices freely—enable the rest of us to obtain a good product at a good price.

Average Janes and Joes and the Health Care Market

When they have good information and freedom to choose health care plans and providers, consumers optimize in classic Economics 101 fashion. For example, the consumer-control, providers freedom to price, and satisfaction data collected by the Twin Cities' employer coalition, the Buyers Health Care Action Group, helped to cause a nearly 20% drop in high-cost/low-satisfaction plans and a 50% increase in low-cost/high-satisfaction plans.[7] Information exerts powerful effects even in the absence of consumer control. When New York provided standardized measures of the open heart surgery performance of hospitals and surgeons, for instance, statewide death rates dropped.[8] Low-performance providers exited and others improved. Market share growth was inversely related to the mortality statistics.[9]

Nevertheless, some policy analysts argue that a consumer-driven health care system cannot work because average consumers will be stymied by the process of selecting among differentiated health insurance products. Instead, the process must be increasingly centralized into their able hands. Notes one: "The approach of trying to give people the purchasing power to operate in the current insurance market assumes too much about individual purchasing abilities."[10]

Although it is hard to understand why we should continue to entrust the selection of health insurance to those who have made such a hash of 15% of our GDP to date, critics like this raise an interesting question: how do average consumers fare when they buy other complicated products, such as cars and mutual funds?

As discussed above, information and a group of assertive consumers are key. Yet another critical element is the changing face of the American consumer. Current generations of Americans are much better educated than prior ones. In 2000, 25.6% of the population had attained a college education or more and 84.1% were high

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[3] *Ward's Automotive Yearbook* (Detroit, MI: Ward's Reports, 2002), p. 202.

[4] Kathleen Kerwin, "At Ford, the More Brands, the Merrier," *BusinessWeek*, No. 3675 (April 3, 2000), p. 58.

[5] "Twenty Years of *Consumer Reports* Surveys Show Astounding Gains," *Consumer Reports*, April 2000, p. 12.

[6] Kevin P. Coyne and Jonathan W. Witter, "What Makes Your Stock Prices Go Up and Down," *The McKinsey Quarterly*, No. 2, 2002, pp. 29–39.

[7] Slide presented by Steve Wetzell of the Buyers Health Care Action Group in a February 1999 meeting of the American Medical Association in Palm Beach, Florida.

[8] Mark R. Chassin *et al.*, "The Urgent Need to Improve Health Care Quality," *Journal of the American Medical Association*, vol. 280, no. 11 (September 16, 1998), p. 1003.

[9] Dana Mukamel and Alvin I. Mushlin, "Quality of Care Information Makes a Difference," *Medical Care*, vol. 36, no. 7 (July 1998), pp. 945–954.

[10] New York Business Group on Health Care (NYBGH), *Conference Proceedings*, "The Nation's Health Insurance System" (New York: NYBGH, 1992), p. 61.

school graduates. In 1960, in contrast, fewer than half the people were high school graduates and only 7% had a college education.[11] Higher levels of educational attainment increased their ability to obtain and interpret information at least as much as their self-confidence. One example of this change is manifested by the Christians who increasingly stand rather than kneel at church, likely to express their notion that a service provides an opportunity for a personal encounter with God, rather than for reverential worship. About 80% of the pews ordered from the country's largest manufacturer now come without kneelers.[12]

Affluent Web surfers also typify the characteristics of this group—they spend much more time than others searching for information on the net before making a purchase and are much more likely to buy, once they have found a good value for the money.[13] Those who focus on their affluence miss the point. Affluent or not, they eat the same bread, buy the same appliances, wear the same t-shirts, and use the same gasoline and oil as we. Their activism improves these products for the rest of us.

Do not get me wrong. If I were Queen, I would push hard to insure universal literacy. But markets function well in the absence of these characteristics, as long as they contain information and a small group of smart, picky, I-want-what-I-want-when-I-want-it-at-a-rock-bottom-price consumers who force providers of goods and services to offer many choices from which they can select.

Health care consumers who typify these characteristics abound. Some express their activism directly by mastering medical skills, such as CPR and the use of external defibrillators.[14] Others search for information, such as the 1.8 million people who spent an average of 20 minutes at the government's National Institute of Health web site, studded with arcane medical journal articles.[15] A 2002 report found that 73 million people in the United States used the Internet for health information, 6 million of them daily.[16]

The assertiveness and self-confidence that typify American consumers are even more strongly evident in the health care Internet users. They agree more than average U.S. adults with the following statements: "I like to investigate all options, rather than just ask for a doctor's advice" and "people should take primary responsibility and not rely so much on doctors."[17] Their pragmatism is apparent too. They do not search idly. More than 70% want online evaluations of physicians,[18] and when they obtain the information, they use it.[19] Nor is consumer assertiveness limited to the United States. For example, 70% of Canadian doctors note that their patients are briefed by Internet information.

Opponents of Consumer-Driven Health Care Systems

The Technocrats

Technocrats who favor centrally controlled systems often doubt the intellectual prowess of anyone other than themselves. They feel obligated to oversee consumers because, in their eyes, consumers are too weak-minded to respond appropriately to information and too timid to help themselves.[20]

Health Policy Perennial Favorite: The Stupidity of Health Care Consumers

We live in an information age, surrounded by ubiquitous newspapers, televisions, telephones, computers, radios, magazines, and books, available worldwide, round-the-clock, that address three of our senses—sound, vision, and, for the vision—and hearing-impaired, touch. The ubiquity of information clearly responds to people's desires. When there is no demand, there is no supply.

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[11] U.S. Census Bureau, *Statistical Abstract of the United States : 2001* (Washington, DC: Government Printing Office, 2002), Table No. 215, p. 139.

[12] "An Uprising in the Pew," *USA Today*, April 16, 2001, p. 1.

[13] Forrester Research, "The Millionaire Online" (Cambridge, MA: Forrester Research, May 2000), p. 11.

[14] "Just Another Day at the Office," *USA Today*, April 16, 2001, pp. 1–2b.

[15] PricewaterhouseCoopers, HealthCast 2010 (New York: PricewaterhouseCoopers, November 2000), p. 22; Scott Reents, Impact of the Internet on the Doctor-Patient Relationship: The Rise of the Internet Health Consumer (New York: Cyber Dialogue, 1999), p. 4.

[16] Susannah Fox and Lee Rainie, *How Internet Users Decide What Information to Trust,* May 2002.

[17] Scott Reents, *Impact of the Internet on the Doctor-Patient Relationship*, *op. cit.,* p. 4.

[18] *Ibid*., p. 2.

[19] Thomas E. Miller and Scott Reents, *The Health Care Industry in Transition: The Online Mandate to Change* (New York: Cyber Dialogue, 1998).

[20] David Burda, "What We've Learned from DRGs," *Modern Healthcare*, October 24, 1993, p. 42; "Wrestling with Medicare Doc Fee Schedules," *Modern Healthcare*, October21, 1996, p. 88.

People use information to inform and amuse. The best information sources combine the two: Morningstar's cute little stars help them buy mutual funds. The pithy reviews in *Zagat's* restaurant guides help them find restaurants. J.D. Power's powerful brand name helps them select automobiles and airlines. And *Consumer Reports'* accurate, comprehensive ratings help them buy virtually everything.

Those who do not like these sources can find many others. If they judge Morningstar excessively terse, the SEC's EDGAR system contains much more information about publicly-traded corporations.[21] If *Zagat* is too trendy, they can turn to the *Boston Globe's* "Cheap Eats" section, or its equivalent in their own hometown paper. If they question J.D. Power's objectivity, they can turn to the federal government's data about cars and airlines, such as those provided by the National Highway Traffic Safety Administration and the Federal Aviation Administration.[22] And, if they feel the *Consumer Reports'* articles are biased against American cars, they can turn to other sources of consumer information, such as *Car & Driver Magazine* and *Consumer's Digest*.

People use information to improve themselves too. In 2004, Bill Gates was the world's richest man because he helped people to become more productive by organizing and processing their information easily and efficiently. Michael Bloomberg became a billionaire because his Bloomberg provided information that helped people to invest in financial instruments with confidence.[23] The endless line-up of self-help *gurus*, from Dale Carnegie, author of *How to Win Friends and Influence People*, to Steve Covey, of *The Seven Habits of Highly Effective People* fame, helped themselves to a tidy fortune, too, as they helped people to help themselves become more effective.[24]

When it comes to health care, the health care-equivalents of J.D. Power and the Zagats can provide the useful, pithy ratings that people crave. And health care entrepreneurs in the Bloomberg and Gates mold can help people to help themselves.

But some of the health care policy crowd have their doubts. They question whether average Americans can use health care information to help them help themselves.

The reason?

Well, to put it bluntly, the average American is not nearly as smart as they.

Then, too, they doubt that good information can be provided. To them, the effect of health care, unlike all other human activities, cannot be adequately measured.

Does the Health Care Market Work Like Other Markets?

The Federal Reserve's chairman, Alan Greenspan, would likely be surprised by this dour assessment of the intellectual ability of the average American. For one thing, the percentage of workers with post-high school education has risen 15% in the past two decades.[25] And in Congressional testimony, Greenspan attributes the surge in the U.S. economy's productivity to Americans' remarkable interest in education: "The average age of undergraduates in school full time has gone up several years. Community colleges have burgeoned in size and on-the-job training has gone up very substantially. They are pressing very hard for higher levels of education and capacity and ability. (Education) has induced a significant increase in their real incomes."[26]

Further, the technocrats' critique implies that professionally trained people are more capable of interpreting complex information. But the technocrats who pooh-pooh others' abilities are not necessarily wizards when it comes to information. For example, in a simple algebra test, only 53% of health care providers—doctors, nurses, and Ph.d.'s—could answer all the questions correctly.[27] After all, if the experts who control the health care system are so wonderful, how did we get into the present mess?

Yet, many studies demonstrate the consumers' ignorance of the ABCs of health care. A perennial favorite in the health policy press is a paper devoted to the sub-

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[21] (EDGAR stands for "Electronic Data Gathering, Analysis, and Retrieval" system.)

[22] See, for example, safety data for cars at and for planes at.

[23] Felicity Barringer and Geraldine Fabrikant, "Coming of Age at Bloomberg L.P.," *The New York Times*, March 21, 1999, p. 1.

[24] Dale Carnegie, *How to Win Friends and Influence People* (New York: Simon & Schuster, 1937). Stephen R. Covey, *The Seven Habits of Highly Effective People* (New York: Simon & Schuster, 1989).

[25] "Blunt Portrait Drawn of U.S. Work Force in 2000," *The New York Times*, August 30, 2002, p. C4.

[26] "State of the Economy," Federal News Service,January 20, 1999.

[27] Carlos Estrada, Vetta Barnes, Cathy Collins, and James C. Byrd, "Health Literacy and Numeracy," *Journal of the American Medical Association*, Vol. 282, No. 6 (August 11, 1999), p. 527.

ject. The writers cluck about the American public's ignorance of the most rudimentary aspects of health care. For example, in 1995, the experts tsk, tsked that 60% of the public were found to think that the health care system was changing slowly or not at all, in direct contradiction to the experts' view of the subject; in 1997, researchers found that many could not explain the terms "HMO" and "managed care" to their satisfaction;[28] and a 2001 report updated this perennial favorite topic with findings that "fewer than one-third of all consumers accurately reported all four health plan attributes."[29]

How would you perform on these tests?

In the eyes of these experts, consumers are not only ignorant but also obdurate, failing to heed useful health care information. For example, consumers' are legendarily indifferent to the health plan performance data contained in HEDIS, a survey by the industry's quality enforcer, the NCQA, that tracks process measures, such as the health plan's rates of immunizations and mammograms.[30]

To my mind, these judgments ignore the fundamental tenet of information-seeking behavior:

Consumers seek only the information that is directly pertinent to their needs.

I cannot describe exactly how cars work. Nevertheless, I am an intelligent buyer of cars because I seek the information that assesses those qualities of an automobile in which I am interested.

Similarly, health care consumers are most interested in provider outcome data for medical conditions similar to their own, treated in a population they consider as peers.[31] Thus it should come as no surprise that Americans cannot describe an "HMO" to the questioners' satisfaction, or that they are uninterested in data about their health plans. Consumers clearly attribute health quality to their providers, not to their health plans.[32] And they are much more impressed by *outcome* data than by reports on *process* measures. Indeed, NCQA rankings had no correlation with consumers' assessments of care by their health plans.[33]

Is the lack of use of the available information an indictment of consumers or an indictment of the poor quality of the data provided?

Two authors concluded that the fault lies largely with information which frequently is not sufficiently comprehensive and relies excessively on the process of care (e.g., mammograms received), rather than its outcome (e.g., breast cancer mortality statistics by provider). And when outcome data are available, they are "so broadly aggregated that the results may be of only limited value to consumers."[34] Further, many users do not trust the data and cannot readily access it; for example, Pennsylvania's risk-adjusted cardiac surgery outcomes by hospital were mailed out only once.[35] Last, most consumers cannot act on the data because they lack choice and control.

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[28] Robert Wood Johnson Foundation, *Community Snapshots Consumer Survey* (Princeton, N.J.: Robert Wood Johnson Foundation, 1995); Princeton Survey Research Associates, *National Survey of American Views' on Managed Care* (Princeton, NJ: Princeton Survey Research Associates, 1997), p. 44.

[29] Peter J. Cunningham, Charles Denk, and Michael Sinclair, "Do Consumers Know How Their Health Plan Works?" *Health Affairs*, Vol. 20, No. 2, March/April 2001, p. 159.

[30] Jon R. Gabel, Kelly A. Hunt, and Kimberly M. Horst, KPMG Peat Marwick, *When Employers Choose Health Plans* (New York: The Commonwealth Fund, 1998).

[31] See, for example, Judith H. Hubbard and Jacqueline Jewett, "Will Quality Report Cards Help Consumers?", *Health Affairs*, Vol. 16, No. 3 (May/June 1997), pp. 218–228.

[32] See, for example, Pacific Business Group on Health, *Report on Qualitative Research Findings: California Health Care Smart Shopper Public Education Campaign* (San Francisco, Calif.: Pacific Business Group on Health, March 1998).

[33] Bruce E. Landon, Alan M. Zavlosky, Nancy Dean Beaulieu, James A. Shaul, and Paul D. Cleary, "Health Plan Characteristics and Consumers' Assessments of Quality," *Health Affairs*, Vol. 20, No. 2, March/April 2001, p. 274.

[34] David W. Bates and Atul W. Gawande, "The Impact of the Internet on Quality Measurement," *Health Affairs*, November/December 2000, p. 106. For an expanded discussion of this topic see also Regina E. Herzlinger and Seth Bokser, "Note on Health Care Accountability and Information in the U.S. Health Care System," Harvard Business School Case No. 302–007 (Boston, MA: Harvard Business School Publishing, 2001).

[35] Bates, ibid.

The Quality of Health Care Quality Information

The most serious objection is voiced by those who point out that quality measures will not be as accurate in 2002 as in 2020.[36] First, the very language for measuring performance has yet to be defined. Second, the risk-adjusters that would make it possible to compare the performance of high-risk specialists to those who treat less-severely ill patients are in an early state of development. Third, the raw data are flawed. For example, the U.S. General Accounting Office found severe flaws in the federal government data bank of the adverse actions taken against physicians and dentists.[37]

These are substantial issues. In the absence of solutions, quality measures will be seriously distorted. For example, a study that compared the rates of caesarian sections in hospitals, with and without adjustment for the patient characteristics that affect the likelihood of needing the procedure, found that risk adjustment caused the performance of five of the twenty-one hospitals in the study to change dramatically; among other changes, two hospitals originally classified as outliers were reclassified as normal and some that were classified as normal were reclassified as outliers.[38] The impact of imperfect measures extends to providers too. Physicians may be dissuaded from caring for very sick patients because of their concern that their outcome measures will not correctly reflect the severity of illness.

Measurement issues like these can be solved with time. Among others, prescient employers in Florida and payors in Washington have already used risk-adjusters successfully.[39] The continually evolving measures of performance of investment management—such as generally-accepted accounting principles and *beta*, the measure of risk of different investments—provides a good example of how difficult measurement problems are solved. *Beta* has been continually refined since it was first suggested in 1952. Similarly, the system used by Morningstar to rate the investment performance of mutual funds evolved over time. Moreover, as the refinement of these measures of financial performance continues, investors have had access to ever-better data with which to evaluate the performance of their mutual funds and stocks.

Patients who put their health on the line deserve no less. As former U.S. Representative Thomas Bliley (R–Va.) noted, the best way to improve the quality of these data is not to suppress them, but, rather, to open them to the public.[40]

How to Obtain Consumer-Driven Health Care Information

Absent governmental involvement that requires dissemination to the public, information that evaluates providers will not be forthcoming. Most voluntary efforts are typically duds—employers simply are not that interested in the data and unclear about how to interpret it and powerful providers may try to suppress it.

The Failure of Voluntary Action

Consider the case of the voluntary Cleveland Coalition to collect hospital performance data. The effort was widely lauded. For example, one hospital claimed that the decrease in its rate of Caesarian Sections from 30% of all births to below 20% were "purely driven by the Cleveland Health Quality Choice."[41] One evaluation concluded that reductions in risk-adjusted mortality rates and lengths of stay were linked to the performance reports.[42] Nevertheless, the effort collapsed when the Cleveland Clinic left the group, allegedly because it did not like the performance ratings it re-

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[36] Joseph P. Newhouse, "Risk Adjustment: Where Are We Now?" *Inquiry*, Vol. 35, No. 2 (Summer 1998), pp. 122–129.

[37] Susan J. Landers, "Physician Data Bank Records Found Inaccurate, Incomplete," *American Medical News*, Vol. 43, No. 47, December 18, 2000, pp. 1–2.

[38] David C. Aron, Dwain L. Harper, Laura B. Shepardson, and Gary E. Rosenthanl, "Impact of Risk-Adjusting Caesarian Delivery Rates When Reporting Hospital Performance," *Journal of the American Medical Association*, 279 (4), June 24, 1998, pp. 1968–1983.

[39] Regina E. Herzlinger, *Consumer-Driven Health Care*, *op. cit.*, see papers by Becky Cherney, "Demanding Quality for Health Care Consumers: The Half-Billion Dollar Impact of Information about Quality," pp. 457–474; Lisa Iezzoni, "Risk Adjustment and Three Case Studies," pp. 242–261; and Vickie Wilson, Jenny Hamilton, Mary Uyeda, and Cynthia Smith, "Health-Based Premium Payments and Consumer Assessment Information as Tools for Consumer-Focused Purchasing," pp. 298–308.

[40] Landers, *op. cit.*

[41] "Project's Collapse Shuts Off Information on Hospital Care Quality," The Plain Dealer, August 23, 1999, p. A1.

[42] Carl A. Sirio and Dwain Harper, "Designing the Optimal Health Assessment System: The Cleveland Quality Choice Example," *American Journal of Medical Quality Care,* 11 (1), Spring 1996, pp. S66–S69.

ceived. Notes a local doctor "What the Clinic really didn't like is that they weren't shown to be the best at everything."[43] The employer community that sponsored the effort did not actively use its results. For example, the only hospital to achieve better-than-expected ratings hoped that the results would yield many new patients as employers referred their enrollees there; but the predicted surge never materialized. Notes one employer, "We weren't that aggressive."[44]

As for the voluntary, industry-led mechanisms for accountability, they are so weak that, for example, *Modern Healthcare,* the industry's leading journal, has repeatedly demanded the resignation of Dennis O'Leary, the head of JCAHO, the national hospital-accreditation group whose governance is dominated by providers. Notes the editorial: "O'Leary and JCAHO have . . . repeatedly failed at initiatives designed to judge hospitals and other healthcare providers based on their performance—how well they take care of sick people. The projects always are announced with much fanfare and heady names such as "Agenda for Change." And they're invariably scrapped, watered down or delayed."[45] An evaluation headed by University of Michigan Professor John Gifford found no correlation between JCAHO scores and outcome measures, including mortality and complications, for the hospitals studied.[46]

Organizations conducting voluntary efforts also frequently dilute their reports to consumers. In Cleveland, for example, the data revealed to consumers were not nearly as precise as those provided to payers. The hospitals agreed not to use them in advertising. As one Cleveland Clinic official noted, "They could confuse the public."[47] Finally, industry—focused efforts rarely reflect the diverse perspectives of all the participants in the system; but these can differ significantly. Consider, for example, the evaluation of Washington, D.C. HMOs that found Kaiser rated near the top by employers, in the middle by users, and near the bottom by doctors.[48]

One of the most important reasons for the absence of provider performance ratings may lie with the providers' considerable political power. "We don't do anything to make providers mad," explained an official about his state's ban on publishing such data.[49] Similarly, the executive director of a Cleveland business council felt that the Cleveland Clinic opted out of an areawide process of measuring hospital outcomes because "they could. They do have a third of the hospitals in Northeast Ohio."[50]

Information as a Public Good

In any consumer-driven system, the government typically plays three crucial roles: overseeing the solvency and integrity of the participants; providing transparency in the market; and subsidizing the purchase of needed goods or services for those who cannot afford them. These are critical for consumer-driven health care.

But the role of government in providing accountability is surprisingly controversial when it comes to health care. Many complain about the absence of good consumer quality information. For example, in a poll performed by a Democratic think tank, nearly 60% of the respondents agreed with a statement that "health care companies and doctors should disclose how well they perform so consumers can judge where to spend their money."[51] The wired generation is even more demanding—80% of respondents noted that the absence of quality information was the most negative aspect of ehealth plans.[52] But not all agree on the role of government in providing it.[53]

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[43] "Operation that Rated Hospitals Was a Success, but the Patient Died," *The Wall Street Journal*, August 23, 1999, p. A1.

[44] *Ibid.*

[45] "Another Provider Files Antitrust Suit," *Modern Healthcare*, December 10, 2001, p. 34.

[46] "Good Scores Don't Equal Good Care," *Modern Healthcare*, January 14, 2002, p. 7.

[47] "Operation that Rated Hospitals Was A Success, but the Patient Died," *The Wall Street Journal*, August 23, 1999, p. A1.

[48] Watson Wyatt, "Purchasing Value in Health Care" (Bethesda, Maryland: Watson Wyatt, 1997).

[49] "Data Needs for Measuring Competition and Assessing Its Impact," *News & Progress* (Washington, DC: Health Care Financing & Organization, July 1999), p. 3.

[50] Regina McEnery and Diane Golov, "Project's Collapse Shuts Off Information on Hospital Care," *The Plain Dealer*, August 23, 1999, p. 1A.

[51] "Health Care Is Back," *Blueprint*, Spring 2000, p. 71.

[52] Bradford J. Holmes, "HMOs' eHealth Plan Threat," Techstrategy Report, Cambridge, MA: Forrester Research, January 2001, Figure 2.

[53] No less an observer than the Nobel laureate economist George Stigler argued against a governmental role in providing data. In his view, the truth will out in markets as competitors expose each others' weaknesses or market analysts dig it up. (See, for example, Stiglitz, J.E., Jaramillo-Vallejo, J., and Park, Y.C. "The Role of the State in Financial Markets." World Bank

Continued

The debate must fundamentally be resolved on a theoretical basis: government's presence in the information market relies on the fact that information disclosure is a public good in the sense that it enables free riders. Because disclosers cannot charge all users for the benefits they derive, they lack incentives for full disclosure. Absent government regulation, the quantity of publicly available information may be undersupplied or issued selectively, favoring some recipients and excluding others.[54]

The Promise of Government: The SEC

Every interest group that has been required to measure its outcomes has likely claimed that its work is so diffuse that its impact cannot be measured. Such claims delayed the measurement of the performance of business enterprises until the mid-1930s. The delay is surprising because accounting, the measurement tool of business performance, has existed since the middle of the fifteenth century when double-entry bookkeeping was first codified.[55] But, executives' claims that accounting could not accurately measure company performance and that the cost of measurement exceeded its benefits prevented the widespread measurement of the economic performance of the firms they led.

U.S. President Franklin Delano Roosevelt (FDR) finally forced their hand when he promulgated the laws that created the U.S. Securities and Exchange Commission (SEC). Bucking powerful business opposition, inconsistent state involvement, and his own advisors' counsel that he grade the firms in the security markets, FDR instead created the SEC to compel audited disclosure, using generally accepted accounting principles (GAAP), about the performance of publicly traded firms. The SEC requires regular compilation of financial statements and their broad dissemination by publicly-traded firms.[56]

Governmental regulation of securities is nothing new. As early as 1285, King Edward I required licensure of London brokers.[57] But FDR's SEC differed from traditional regulation that relied on authorities to evaluate the worthiness of a security. He opted for sunlight. As he noted: "The Federal Government cannot and should not take any action that might be construed as approving or guaranteeing that . . . securities are sound. . . ." Rather, his SEC was a "truth" agency to insure full disclosure of all material facts. In Roosevelt's words, "It puts the burden of telling the truth on the seller."[58]

As in health care, there was plenty of truth waiting to be told. Requirements for listing securities on the stock exchange were minimal and there was no source of generally accepted accounting principles. In 1923, only 25% of the firms traded on the New York Stock Exchange provided shareholder reports.[59]

To put teeth in its mission, the SEC was given the power to enforce "truth in securities" and to regulate the trading of securities in markets through brokers and exchanges. While the SEC requires disclosure, the promulgators of GAAP have been housed in private, nonprofit, standard-setting organizations, such as the Financial Accounting Standards Board (FASB). The successful European Union model for set-

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Research Observer, 1993, pp. 16–61; Dutt, J. "Unlikely Adversaries: Top Regulators in Dispute over Plan to Change Accounting Rule on Derivatives." Washington Post, Aug. 24, 1997, p. H1.) Stigler's analyses concluded that government regulation of information disclosure was not essential to the efficiency of markets. In this view, if information is beneficial to the firm, its managers will advertise it; if it is detrimental, the firm's competitors will trumpet it; and if it exists, whether good or bad, analysts will ferret it out. No need for government. (John Carey, The Rise of the Accounting Profession (New York: American Institute of Certified Public Accountants, 1970), pp. 1–16.)

As is usual with works of such significance, Stigler's analysis and similar research were widely tested. (Joe Seligman, The Transformation of Wall Street (Boston: Houghton-Mifflin, 1982), p. 41; Regina E. Herzlinger, "Finding the 'Truth' About Managed Care," Journal of Health Politics, Policy, and Law, 24 (5) (October 1999), pp. 1077–1093.) Yet, the abundant, intelligent empirical research examining the necessity of government action to ensure an efficient market has not yet settled the question.

[54] Eventually, of course, all users could share the same information, but some would gain temporal advantage because they learned special information earlier than others; however temporary, this advantage violates our national notions of equity.

[55] Michael Chatfield, *A History of Accounting Thought* (Huntington, NY: Robert E. Krieger Publishing, 1997), p. 32.

[56] Joel Seligman, *The Transformation of Wall Street* (Boston: Houghton-Mifflin, 1982), p. 41.

[57] Fred Skousen, *op. cit.*, p. 2.

[58] Joel Seligman, *op. cit.*, pp. 54–55.

[59] Joel Seligman, *op. cit.*, pp. 43–48.

ting standards in health, safety, environment, and consumer protection follows a similar public-private structure.[60]

Like all human endeavors, the SEC is not without faults. The accounting and governance problems of Enron—a firm that, by 2002, was the nation's largest bankruptcy—were exacerbated by laxity in SEC enforcement.[61] Nevertheless, the transparency created by the SEC enabled the celebrated broad participation of average Americans in the securities markets and their legendary efficiency.[62]

Accounting was not nearly an accurate a measure of performance in 1934 as it is now. And no doubt accounting will become much better still in the future. That is the way it is with all measuring tools: they improve with use. In 1687, Newton first measured gravity. By 2000, physicists could measure the minute energy of a *tau-nutrino* buried deep within an atom.[63] In 1953, Crick and Watson first measured the structure of DNA. By 2001, biologists could measure the structure of individual genes.[64]

So too, with health status measures. Epidemiologists can now create relatively crude measures of health quality. But, with practice and patience, they will refine those measures of outcomes and relate them more accurately to their causal agents.

Private Sector Sources of Health Information

Surprisingly, much of the information that lies at the heart of the efficiency of the markets wells not from the SEC but from three private sector groups: the firms, FASB, and accounting profession. The interaction among these groups promotes fuller consideration of diverse points of view. Unlike a government agency, they do not sing out of one hymnal. And their private-sector nature requires the political and financial backing of supporters for their continued existence. The predecessors to the FASB collapsed because their GAAP pronouncements could not find such broad-based supports.

The independent accountants who audit the financial statements are usually professionals who must pass examinations and fulfill stringent educational requirements.Many work in one of the large accounting firms that audited nearly 80% of the publicly traded firms.Accounting firms may be held legally liable for negligence, fraud, and breach of contract.

Initially, in abdicating some of its authority to set accounting standards to the private sector, the SEC recognized the following advantages:[65] (1) Practicing accountants were closer to the firms and thus could more accurately identify emerging issues; (2) private sector involvement encouraged greater compliance than government mandates; and (3) the SEC could more readily audit the work of the private sector information disclosers than its own, thus resolving a conflict of interest. But the accounting abuses that emerged in 2001 and 2002 caused a shift in this stance. It appeared that the financial statements of massive firms, such as Enron and Global Crossing, did not accurately reveal their underlying economic status, despite audits by leading accounting firms and reviews by the Audit Committee of the Board of Directors.[66] In Enron's case, for example, much of the company's debt was lodged in special-purpose entities that were not consolidated in the financial statements.

Many blamed the structure of the accounting firms for these debacles, citing the conflict of interest created by their simultaneously offering lucrative consulting and low-profit auditing services to their clients. Past SEC attempts to bar accountants from offering consulting contracts were stymied by the Congress.[67] This time around, the SEC relied on its internal rule-making authority to reclaim some of its powers. In 2002, it introduced rules to prompt faster, more complete disclosure and

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[60] Walter Mattli, "Global Private Governance for Voluntary Standards Setting: National Organizational Legacies and International Institutional Biases," Regulatory Policy Program Working Paper RPP–2001–06, Center for Business and Government, John F. Kennedy School of Government, Harvard University (May 2001).

[61] Bethany Mclean, "Why Enron Went Bust," *Fortune*, Vol. 144, No. 13 (December 24, 2001), pp. 58–68.

[62] See, for example, Joel Seligman, *The Transformation of Wall Street* (Boston: Northeastern University Press, 1995), pp. 561–568.

[63] Bertram Schwarzschild, "The Tau Neutrino Has Finally Been Seen," *Physics Today*, Vol. 53, No. 10 (October 2000), pp. 17–19.

[64] Leslie Robert, "A History of the Human Genome Project 2001," *Science*, Vol. 291, No. 5507 (February 16, 2001), pp. 1195–1200.

[65] Richard E. Baker, "Accounting Rule-Making—Still at the Crossroads," *Business Horizons*, vol. 19, no. 5, October 1976, p. 66.

[66] Steve Pearlstein, "The Whole Story?" *The Washington Post*, May 12, 2002, p. H01.

[67] "SEC Chief to Impose 'Stringent' Rules on Accountants," *The Buffalo News*, May 24, 2002, p. A9.

to create a new entity to oversee the accounting professionals.[68] Similarly, the rule-making Financial Accounting Standards Board hoped to simplify and streamline its occasionally complex rules.[69]

The Health Care SEC

The U.S. securities markets have precisely the characteristics that health care consumers want: (1) prices are fair in the sense that they reflect all publicly available information; (2) buyers use this information to reward effective organizations and penalize ineffective ones; and (3) information and competition continually reduce costs.

If these characteristics were present in health care, they would achieve an important social goal: *They would divert resources from health insurers and providers that offer a bad value-for-the-money to those that offer a good one. Poor-value-for-the-money insurers and providers would shrink or improve. Good-value-for-the-money insurers and providers would flourish.*

Currently, health care consumers have better information about the price and quality of the jar of tomato sauce they buy than for the surgeon who will operate on their breast or prostate cancer. Publication of price and quality data for individual providers, as measured by generally accepted health care outcome principles and audited by certified, independent appraisers of such information, will help ameliorate this problem. Eventually, independent analysts will use this information to compile readily accessible ratings of providers, just like Morningstar's excellent system for classifying and rating mutual funds.

New York State experience illustrates the results when government requires meaningful health care information. Using his clout, in 1989 New YorkState's commissioner of public health requested data about the risk-adjusted death rates of open-heart surgeries performed by different surgeons and hospitals. As a result, by 1992, the state achieved the lowest risk-adjusted mortality rates in the country.[70] Physicians and hospital executives with low-performance scores typically revamped their protocols in response to these data.[71] Most studies found that the fears that surgeons would abandon sick patients to improve their performance ratings to be unfounded: To the contrary, the severity of illness among New York patients having coronary artery bypass graft (CABG) surgery increased.[72] Although one excellent study concluded that the ratings led to "a decline in the severity of illness" of CABG patients, it cautioned: "Our results do not imply that report cards are harmful in general. . . . [R]eport cards could be constructive if designed in a way to minimize the incentives and opportunities for provider selection."[73]

Similar results were obtained in other instances of required performance disclosure. When Minnesota's state government required all insurers who served state employees to be evaluated by their enrollees in a report card, some plans restructured significantly to improve their quality ratings.[74] Similarly, the Pennsylvania hospitals whose performance data were measured and disseminated by a public agency used the results to change their patient care and governance to a greater extent than neighboring New Jersey hospitals whose performance data were not released. The important changes included Board reviews of the data and reworkings

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[68] "SEC Seeks Reform in Financial Disclosure and Auditor Oversight," *Chemical Market Reporter*, March 4, 2002, p. 18; Jonathan D. Glater, "SEC Proposes a New Board to Oversee Auditors," *The New York Times*, June 21, 2002, p. C1; Richard Simon & Walter Hamilton, "Accounting Reform Bill Gets a Boost; Regulation: Senate Panel Approves Measure That Would Create Oversight Board and the SEC Pushes Parallel Proposal," *Los Angeles Times*, June 19, 2003, part 3, p. 1; and John Labate, "Plan Supports Proposals by SEC Chairman Harvey Pitt," *The Financial Times*, March 8, 2002, p. 7.

[69] "FASB: Rewriting the Book on Bookkeeping," *BusinessWeek*, May 20, 2002, p. 123.

[70] Edward L. Hannan, Albert L. Siu, Dinesh Kumar, and Mark R. Chassin, "The Decline in Coronary Artery Bypass Graft Surgery Mortality in New York State," *Journal of the American Medical Association*, Vol. 273, No. 3 (1995), pp. 209–213; S.W. Dziuban, "How a New York Cardiac Surgery Program Uses Outcome Data,"*Annals of Thoracic Surgery*, Vol. 58, No. 6 (1994), pp. 1871–1876.

[71] Mark R. Chassin, "Achieving and Sustaining Improved Quality: Lessons from New York State and Cardiac Surgery," *Health Affairs,* Vol. 21, No. 4 (July/August 2002), pp. 40–51.

[72] E.D. Peterson, E.R. DeLong, J.G. Jollis, L.H. Mulbaier, and D.B. Mark, "The Effect of New York's Bypass Surgery Provider Profiling on Access to Care and Patient Outcomes in the Elderly," *Journal of the American College of Cardiology*, 32 (8), October 1998, pp. 993–999.

[73] David Dranove, Daniel Kessler, Mark McClellan, Mark Satterthwaite, "Is More Information Better? The Effects of 'Report Cards' on Health Care Providers," National Bureau of Economic Research, working paper w8697, January 2002.

[74] "Health Plan Report Cards May Influence Insurers More than Consumers," Findings Brief, *Health Care Financing & Organization,* Vol. 3, No. 3, April 2000.

of the patient care procedures.[75] And all these results were obtained in the absence of consumer control.

How To Make It Happen

The key to achieving these desirable characteristics in health care is legislation that replicates these essential elements of the SEC model:

1. **Registration:** The SEC requires firms that trade their securities in interstate markets and all such market-makers to register with the agency. A corresponding health care agency would oversee the integrity and require the public disclosure of information for health insurers and providers, the policies they issue, and the interstate markets in which such insurance policies and services are sold. It would be armed with powerful penalties for undercapitalized and unethical market participants.
2. **Private Sector Disclosure and Auditing:** The SEC relies heavily on private sector organizations. The new health care agency would delegate the powers to derive the principles used to measure the performance of insurers and providers to an independent, private nonprofit organization that, like the FASB, represents a broad constituency. The agency would require auditing of the information by independent professionals, who would render an opinion of the information and bear legal liability for failure to disclose fairly and fully.
3. **Private Sector Analysis:** The evaluation process is primarily conducted by private sector analysts, who disseminate their frequently divergent ratings. To encourage similar private sector health care analysts, the new agency would require public dissemination of all health insurance prices, related transaction costs, and the characteristics of the policies and providers, such as clinical measures of quality.

Private Sector Sources of Analysis

Will private sector intermediaries emerge to provide the information that consumers need? Some examples of the entrepreneurial health care quality information providers who already exist are described below.

Andy Slavitt is an early-thirties California type and an MBA all-star, with Wharton and HarvardBusiness School degrees and a spell at McKinsey's famed Los Angeles health care practice.

Slavitt was propelled by a personal loss into founding a firm that empowers health care consumers with information. His inspiration came when a friend's wife turned to Slavitt for help after her husband died of cancer. She was surrounded by mounds of medical bills, whose bulk was matched only by their incomprehensibility. Slavitt, the MBA all-star, was a sensible choice to help her plow through the paper. But Slavitt, the social activist, was an even better choice. He is as intense about his societal interests as his business ones. For example, Slavitt traveled to El Salvador to help build housing in that war-ravaged country.

These two sides of his being meshed as he organized her medical bills. On the social side, Slavitt wondered if the bills' lack of transparency and sheer volume seemed to be designed to take advantage of a vulnerable, grieving person. On the business side, he was outraged by charges to an individual that vastly exceeded the charges for the same services to large groups. And, try as he might, Slavitt could not link the charges to the actual care received.

If Andy Slavitt, all-star MBA and health care analyst, could not analyze these questions, who could?

HealthAllies, the firm Slavitt created for uninsured or underinsured people, helps answer these questions. For one, it empowers its users by providing information about the prices for medical care alongside the credentials of those providers. It also offers them discounts on health care prices similar to those obtained by large groups. And consumers can obtain prices for bundles of care, rather than à la carte services. For example, a pregnant woman can obtain a discounted fee for the entirpe maternity and birth process from her choice of providers through HealthAllies. Last, the website provides links to information about providers.

Had the HealthAllies site been available to the wife of Slavitt's friend, she would have received one bill for the bundle of care given to her husband, rather than hundreds of individual ones; she could have easily compared her price to those charged by other providers, and she could have obtained the same discounted rate as large group buyers.

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[75] J. Margin Bentley and David B. Nash, "How Pennsylvania Hospitals Have Responded to Publicly Released Reports on Coronary Artery Bypass Graft Surgery," *Journal on Quality Improvement*, 24 (1), January 1998, pp. 49–49.

Consider the following illustrative case:

> *A woman who needs a hip transplant inquires about the charge at an academic medical center. She is quoted a price of $35,000. (In hotels, this kind of price is known as the "rack rate" quoted to individual customers who lack the bargaining power of a group.) She then logs on the HealthAllies site to search for a better hip-transplant price. In response to her specifications about the type of providers she wants (for example: a surgeon who has performed more than 75 hip transplants and who operates in an academic medical center that has performed more than 500 hip transplants last year and that is located within 30 miles of her home), she chooses a hospital that quotes a price of $25,000. Ironically, it is the same hospital that initially quoted the $35,000 price.*

To insure that its interests are squarely lined up with the user, HealthAllies' revenues are derived from savings it creates for the consumers and their employer.[76]

In 2003, United Healthcare purchased HealthAllies. It now offers essential health coverage policies at prices ranging from $500 to $3,000 to the uninsured in the costly New York market.

Ingenix, another subsidiary of United, has total cost estimators that represent the average annual treatment cost for chronic diseases and conditions, as well as length-of-episode treatment for acute diseases and conditions with drill down capability, by zip code. The cost ranges represent aggregated and scrubbed billed charges as they appear on claim forms submitted by the health care professional or facility, as well as net of reductions for invalid or ineligible charges, such as non-covered consumers, services, etc. Costs are displayed as point estimates using relative and actual charge data, along with allowed charges. In-Network averages are calculated at the 50th percentile of allowed charges and Out-of-Network averages are calculated at the 80th percentile of billed charges. Ranges indicate the inherent variability in health-care costs.[77] Acton, Massachusetts-based HealthShare has similar data for 30 health plans.

As of yet, firms do not offer their data to consumers because of the high cost of customer-acquisition. But a consumer-driven health care would open up the entire, large U.S. insurance market to them. In the United Kingdom, similar services are already marketed to self-pay patients who wish to avoid the NHS waiting lists. They include HealthCare Navigator and Medical Care Direct, firms similar to HealthAllies.[78]

Other Health Care Information Services

Many other sources of information exist. Indeed, clinical health information sources are so easy to find that they are virtually unavoidable. They appear regularly on radio and television, typically in patronizing lectures from your local blank-eyed, blow-dried hair, reading-off-the-Teleprompter "Health Beat" type of announcers (ugh); in newspaper features (good); and in magazines devoted solely to the topic (better still). For example, *Prevention* sold more than 3 million copies a month in outlets such as the check-out area in a supermarket in 2001.[79] Many authoritative health care books are available as well, including best sellers such as *Mayo Clinic Family Health Book*.[80]

The web is a major source of health information. It not only enables mass-customization of information, but also facilitates consumers' feedback about the quality of their health care experiences. This kind of information is much valued. For example, a KPMG survey of almost 15,000 employees of the *Fortune 1000* revealed that they placed the highest trust in information received from friends and family.[81]

Nevertheless, substantial market needs remain largely unserved. A 2000 survey revealed that the information that consumers sought most was largely unavailable.

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[76] Michael Sherman and Regina E. Herzlinger, "Health Allies," Harvard Business School Case No. 302–019, Rev. September 2002 (Boston, Mass.: Harvard Business School Publishing, 2001).

[77] Ingenix, communication to author, June 18, 2004.

[78] "The Good Hospital Guide," Sunday Times, April 6, 2003 and "Private, I?", accessed June 20, 2004.

[79] Audit Bureau of Circulation (ABC), published on AdAge.com, January 17, 2003.

[80] David E. Larson, *Mayo Clinic Family Health Book* (New York: William Morrow, 1996).

[81] "A New Direction for Employer-Based Health Benefits," KPMG, LLP, publication 99–12–05, November 1999.

While most of the available information focuses on diseases, over 50% of respondents wanted additional information: evaluations of doctors, hospitals, and insurers, e-mail reminders, and personal medical reports.[82] A 2002 review of 40 physician directory websites found many incomplete, inaccurate, and out-of-date.[83]

A number of web sites serve the general "rating" market. For example, consumers can post their reviews of products and retailers on Epinions.com, BizRate.com, and ConsumerReview.com. There are even professional raters of the raters. For example, a *New York Times* article critically evaluated the sites that rated cars, including the web site of the *Kelley Blue Book*, lycos.com Auto Section, and the ultimate winner of that evaluation, the venerable consumerreports.org.[84] The felicitously named Quackwatch.com is among those which perform this review function for health care. Formed by a retired psychiatrist, it features more than 100 doctors on its board. The organization cooperates with the National Council Against Health Fraud and *Consumer Reports*.[85]

Nevertheless, good sources for health care information are hard to find. As the old blues song noted of men, you always get the other kind.[86] Sure, plenty of data are available; but absent requirements to disclose it, information about the quality of health care providers, which is what people want and need to make intelligent decisions, remains notable for its absence.

How Not to Make It Happen

Unfortunately, many well-intended proposals undermine one or more of the essential characteristics of the SEC. All-too-often, they require that the health care regulator(s) evaluate and micromanage health insurers and providers and the markets in which they operate.[87] One proposal, for example, blurs the distinctions between information and evaluation, between oversight and micro-management: Its FASB analogue evaluates quality and its SEC analogue evaluates health care benefits and coverage problems. But the real FASB does not assess the quality of the output produced by corporations, nor does the real SEC evaluate whether the markets for the products that corporations sell yield effective, efficient outputs. Instead, they ensure the provision of reliable, useful information that private sector intermediaries analyze and present to other investors.

Other proposals create conflict-of-interest by requiring that existing governmental purchasers measure quality. In recent testimony, for example, the head of AHRQ, the HHS agency charged with researching quality, presented a bone-chilling description of Federal government efforts not only to measure but also to design the information highway on which quality data would travel. Everybody knows that Medicare's actions are soon followed by the other insurers. Her description thus amounted to allowing the single largest payer to dictate the components of health care quality and the IT system that transmits it. No competition, lots of politics—is this anyway to run a market?[88]

The much-abused U.S. uninsured health care consumer needs, and wants, quality health care at an affordable price. We know that the SEC model works in providing such information to investors. We just need to take advantage of it in a consumer-driven health care system.

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[82] Scott Reents, *Impact of the Internet on the Doctor-Patient Relationship: The Rise of the Internet Health Consumer* (New York: Cyber Dialogue, 1999), p. 5.

[83] The Commonwealth Fund, "Accessing Physician Information on the Internet" (New York: Author, January 2002).

[84] Michelle Slatalla, "Turning the Tables to Rate the Raters," *The New York Times*, March 23, 2000, p. D4.

[85] "Quack Patrol At Your Service," *Los Angeles Times,* March 23, 1998, p. S1.

[86] Dagmara Scalise, "Who's Rating You?" *Hospitals & Health Networks*, December 2001, pp. 36–40.

[87] See, for example, "Bush Is Said to Be Set to Back Patient's Bill," *New York Times*, June 7, 2002, p. A16.

[88] Carolyn M. Clancy, "AHRQ: A Tradition of Evidence," *Health Management Technology*, Vol. 24 (8), August 2003, pp. 26–31; Patrick S. Romano, Jeffrey J. Geppert, Sheryl Davies, Marlene R. Miller, et al., "A National Profile of Patient Safety in U.S. Hospitals," *Health Affairs*, Vol. 22 (2), March/April 2003, pp. 154–163; and Barbara Morris, "AHRQ's New Prevention Quality Indicators," *International Journal of Health Care Quality Assurance*, Vol. 15 (2/3), 2002: 1–2.

Chairman HOUGHTON. Thank you very much, Dr. Herzlinger. I would like to yield to Mr. Thomas.

Chairman THOMAS. Thank you very much, Mr. Chairman. Dr. Kane's statement is just classic, that it is just as charitable to charge a rich man as a poor man, which may be the theme of why we are looking at pricing under the 501(c) section of the Code.

Ms. Davis indicated that she could quantifiably differentiate between a not-for-profit and for-profit in terms of charitable activities. I am going to ask each of you if you believe you have seen sufficient data in which you can create a clear separation between not-for-profit and for-profit hospitals broken along a charity of a community service line. If you don't have that information, that is fine. I just need to know if everyone agrees with that particular position based upon the data and the evidence that you are familiar with. Dr. Kane, yes or no?

Ms. KANE. Yes, I have seen a difference. Generally the nonprofits do provide more free care, although the uncompensated care totals can be quite similar. The problem with nonprofit, it is hard to generalize about them. I think there are quite a few more of them, and so you will see a wider range in behavior.

Chairman THOMAS. I agree, and I have additional questions to follow up on that. Dr. Ginsburg, yes or no, in terms of a differentiation, in terms of charitable or community service between not-for-profits and for-profits?

Mr. GINSBURG. Yes. My recollection of the research literature is similar to Dr. Kane's, that we do see charitable care by for-profit hospitals, but we see more by nonprofits.

Chairman THOMAS. Mr. Lee.

Mr. LEE. Defer to my research experts up here. It is not an area that we have looked at closely.

Chairman THOMAS. That is fine. Dr. Herzlinger?

Ms. HERZLINGER. I think the question is: do nonprofits give enough charitable care——

Chairman THOMAS. That is my next question.

Ms. HERZLINGER. To render their tax exempt——

Chairman THOMAS. That is exactly the next question.——

Ms. HERZLINGER. I think that is—Ms. Davis is quite correct. Nonprofit hospitals do give more charitable care, but of course they should. They are tax exempt. We give them major tax subsidies to provide charitable care. We don't give those to for-profit hospitals.

Chairman THOMAS. Doctor, thank you for the bridge. That is exactly the question that I now need to ask, because all of you felt fairly comfortable, and one of you deferred to the others on the information that is available, that there is a difference between the not-for-profits and the for-profits.

My next question, obviously, then is: do you think it is measurable enough to deal with the significant difference in the way not-for-profits and for-profits are handled under the Tax Code? I will start again with Dr. Kane. Yes, no, or not enough information to make a decision?

Ms. KANE. Could you rephrase your question, please?

Chairman THOMAS. If in fact we all agree that not-for-profits do carry out charitable or community services that give us an ability to differentiate, perhaps not across the board, but substantially be-

tween the not-for-profit hospital group and the for-profit hospital group. Do you believe we have sufficient information, or are you comfortable in saying, yes, you can differentiate between the two, and the not-for-profit status of the 501(c) tax-preferred status of the not-for-profits is therefore appropriate, given the difference in the charitable services of the not-for-profits versus the for-profits?

Ms. KANE. You don't have enough information. First of all, I don't think you can even tell what the value of tax-exempt status is for a lot of these hospitals, and then again, the transparency issue, the lack of reporting and information, makes it very difficult right now to tell. In the research I have done, most nonprofit hospitals do not earn the value of their tax exemption through the provision of charity care. They do provide other community benefits. It is differential. It varies a lot across the population. We do not know how to properly value some of those services, so we don't have the information.

Chairman THOMAS. Dr. Ginsburg.

Mr. GINSBURG. I don't have anything to add to what Dr. Kane said.

Chairman THOMAS. Mr. Lee.

Mr. LEE. I don't have an answer relative to the specific qualification, but I would add one other element to your question if I could, Mr. Chairman, which is to consider not just the relative contribution to charity care, but also how nonprofit hospitals play in the market as they too, may act as over-consolidated entities which look very similar to for-profit entities, and that is another element to consider.

Chairman THOMAS. I can assure the gentlemen we are going to get there.

Mr. LEE. Okay.

[Laughter.]

Chairman THOMAS. Ms. Davis.

Ms. DAVIS. There is evidence that charity care is being increasingly concentrated in fewer and fewer hospitals, not all of them do it. Certainly there is evidence on other community benefits that are provided in the form of standby capacity like——

Chairman THOMAS. The focus of the question was do you have enough information to say you feel comfortable that the difference between the tax treatment of not-for-profits and for-profits is justified based upon the charity or community work they do?

Ms. DAVIS. We do have quantitative estimates of community benefits for medical education, standby capacity and charity care.

Chairman THOMAS. In your opinion, is it enough to justify the tax difference?

Ms. DAVIS. Yes, on the whole.

Chairman THOMAS. Okay doctor, I understand where you are. Very quickly. On page 6 of your testimony, Dr. Ginsburg, I do have to fundamentally disagree with you, where you say that over the long haul advancements in medical technology are far and away the biggest factor in rising costs.

One of the difficulties I have had is assuming that somehow medical technology is always a cost driver and not a cost saver. I really believe the problem is that you are introducing medical technology in fundamentally a cost plus structure. In a cost plus struc-

ture, medical technology will always cost more, but if you deal with a comprehensive payment in which you have accepted responsibility and your profit is what is left over, that cost structure is a significant driver to use medical technology to save money, i.e., increase your profit, and so I am very concerned that people automatically dismiss medical technology as though medical technology itself was the problem. It is not.

In my opinion, it is the payment structure in which medical technology is introduced. I just wanted to clarify that because people so often say medical technology is the reason costs are going up. No, it isn't. It is the structure and the mechanism by which we pay and utilize medical technology.

Mr. GINSBURG. I would differentiate between the capitated environment which has the incentives to use only valuable technology, and the fee-for-service environment, which unfortunately is our dominant payment mechanism, which tends to accept almost all technology.

Chairman THOMAS. Doctor, I accept that correction, but your statement is a stand-alone flat-out statement. That is all, and I just said that I would have some concern with that statement as a stand-alone statement.

Mr. GINSBURG. I think the other point I want to make is that there is so much dynamic in medical care, so that the services that people are getting over time are changing. People are getting more medical care, much of it valuable, and this is the key reason why spending per person increases.

Chairman THOMAS. I agree. Increased usage isn't necessarily medical technology. It is awareness, availability, education. All of those are factors that have dollar values to them. I was just focusing on the medical technology statement that you made.

I also have to say that your statement, disclosed prices will lead to higher prices, is about the most anti-market statement I have heard in a long, long time, because what hospitals receive and what third-party payers, the primary function of paying, is a negotiated price. When you talk about disclosing prices, those are mainly out there to make sure you get more payments from the government, not that they are any real standard of what the prices are. In attempting to determine the initial statement that I asked, whether or not there was a differential that could be seen and value gotten from the tax treatment, prices are fundamental to what we need to focus on. Let me ask only one additional question. Thank you, Mr. Chairman, for the time. Mr. Lee, when you looked at the differential in quality and cost on a quintile or a quartile structure, did you break it down between not-for-profit and for-profit as well as the structure that you outlined?

Mr. LEE. We have not done a full review of that, but we have that information, and right now when you look at this quartile mix, it is really sort of a scatter all across the map of where hospitals fall on efficiency and quality. I will look at it more closely and follow up with you, Mr. Chairman. My recollection that it is a mix among nonprofit and for-profit, where they are scattered amongst this mix of efficiency and quality.

Chairman THOMAS. Mr. Chairman, as we examine the question, we shouldn't just focus on community or charitable care as it may

be defined. It seems to me that given the significant tax break that not-for-profits provide, we should see to a certain degree discernible differences among a number of axes that you would examine the materials, and I would submit that that is not the case now, or we don't have enough evidence to make that decision, and I would hope people don't believe as a general position that transparency and knowledge to consumers is a dangerous thing. It is the most important thing to getting some rational payment and quality structure in this area as far as I am concerned. Thank you very much, Mr. Chairman.

Chairman HOUGHTON. Again, I turn to Mr. Pomeroy. Mr. Thomas, I thought we would have a second round with the exception of you, because you had two positions here. Is that all right with you?

Chairman THOMAS. I am under the complete control of the Chairman.

[Laughter.]

Chairman HOUGHTON. Okay, Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Well, we have a rich stew of health policy ideas bubbling in this hearing, not really leading any direction, but we got a rich stew on our hands. I guess to the extent it relates to this issue of not-for-profit and their role in providing charity care, the panel is in agreement that there is a distinction in the market practices of not-for-profit versus proprietary institutions. There also seems to be agreement that not-for-profit, the basis for not-for-profit status as a hospital, ought to be considered beyond the issue of charitable care or uncompensated care, role in the community, community service, or other things appropriately considered. Any objection with those kind of general conclusions so far?

[No response.]

All right. I think a third point of consensus that I understood is more data to the public in understandable ways involving cost, but very importantly, also involving quality would be of great value.

[No response.]

Consensus again. All right. Well, let us kind of wade into areas where we might have some differences of opinion. Ms. Herzlinger, first of all, congratulations on raising a fine son, and our full support is with Captain Herzlinger and his important responsibilities on behalf of all of us in Iraq today.

Ms. HERZLINGER. Thank you.

Mr. POMEROY. It seems to me that you place a very important role on market dynamics. If we could get market dynamics into health care providing, it would be a big step forward. Do you believe abolishing employer-based health insurance for some other kind of comprehensive coverage is then a step in that direction?

Ms. HERZLINGER. I think it is very important that people have access to money that enables them to buy health insurance. Right now that money comes from employers, but it is really paid by employees. They just get paid in the form of health insurance rather than getting paid in the form of salaries.

Mr. POMEROY. Although there are some marketplace dynamics that captures. I mean distribution, discounts.

Ms. HERZLINGER. Perhaps. Although if the distribution were so powerful we would have our employers buying our cars for us, they would buy our food for us, they would buy our housing for us.

Mr. POMEROY. I am not sure of this car deal. I mean I kind of think, I like my car, Ford Escort, runs fine, but I think quite differently about health.

Ms. HERZLINGER. Yes, but that is——

Mr. POMEROY. I buy a cheap car because it gets me around. When it comes to my health, I don't want cheap. I want good.

Ms. HERZLINGER. You want value for the money.

Mr. POMEROY. I think that this analogy just didn't quite go all the way, but I was trying to get to what you imagine as a perfect coverage scheme.

Ms. HERZLINGER. Correct.

Mr. POMEROY. Would it be government provided?

Ms. HERZLINGER. My point was, Congressman, that the idea that big is beautiful, that big buyers create efficiencies in the market. If that were so, then all consumer goods would be purchased through big buyers rather than through consumers. Yet, most consumer goods are purchased, you and I buy our own clothes, we buy our own house, we buy our own food. We buy many things for ourselves, and we get good values for the money.

Mr. POMEROY. This is an interesting discussion in economics. I don't quite understand its application to what we have before us as a point of inquiry.

Ms. HERZLINGER. Well, you——

Mr. POMEROY. I really don't have time, unfortunately, to ferret it all out, because there is a couple things I want to get to beyond that. Probably, Dr. Kane. It seems like our pricing, it has had an evolution. Hospitals are, from the beginning of time, I suppose, they get paid by some, not for others, got to provide care for all. So, over time they developed a pricing way of making sure they recovered enough from those who paid to cover those who didn't pay, and in the era that we are in, be it Medicare on one hand or third-party payers on the other, they have been pretty effective at ferreting out where the cross-subsidies are for those not paying, and they don't pay for them anymore. They pay cost, not this cost plus a subsidy for those not paying and at the end of the line is the hospital, therefore, as you point out, charging the private uninsured more, because there is no discounts attached, than the others now pay.

However, as this has evolved where those with coverage used to pay more to cover those without coverage, now the uninsured are billed more than those with coverage. The difference for a hospital is that they are very unlikely to recover from those without coverage. So, although they are billed more, they are not paid more from this group; is that correct?

Ms. KANE. I think the average amount you recover from your people who would classify as uncompensated care is around 20 percent of cost, and that is the hospital's side of the experience. If you are a medical debtor, you have a very different experience even if you don't pay your full bill. You still can get harassed. You can still lose your house. You can still have your wages garnished. You can still be afraid to go back into the health care system for the next

round. So, even though they don't pay their full costs, most of those who are eligible for medical bad debt or free care don't pay their full cost, they are still, particularly the bad debtors, experiencing financial angst.

Mr. POMEROY. Absolutely. In North Dakota, where I am from, I mean it is our leading cause of bankruptcies among farmers. It is a big deal. I will look forward to the second round, Mr. Chairman. So, much more to cover.

Chairman HOUGHTON. Thank you very much. I would like to ask a question of Dr. Ginsburg. I think you mentioned two things, one, using the insurers more to determine the pricing strategy, and also you talked about the hospital networks. Do you want to elaborate on those two things?

Mr. GINSBURG. Yes. I think one of the most important innovations associated with managed care has been in purchasing, in a sense by developing a network of providers who have come to an agreement with the insurer about rates. This is a very effective mechanism for obtaining a lower price for the policy holders, and probably a lot better than they could do on their own even if they had a lot more price information than they do.

Chairman HOUGHTON. Any more?

Mr. GINSBURG. I would say that the—obviously the——

Chairman HOUGHTON. You don't have to go on. That is fine.

Mr. GINSBURG. Well, let me say that the one other point is that the network tool starts breaking down to the degree that consumers or employers demand that all hospitals be in the network, then that removes the leverage that the health plan would have with the hospital, and that issue is what the tiered network is trying to respond to.

Chairman HOUGHTON. All right. Mr. Stark, would you like to inquire?

Mr. STARK. Thank you, Mr. Chairman. Dr. Kane, in your review of foregone taxes, I guess, are you taking into account only Federal income taxes, or do you take into account real estate taxes paid locally, or forgiven locally?

Ms. KANE. The study I did it about, using '95 data, so it is old, was property tax, sales tax, State income tax, and Federal income tax, not including the value of tax exemption, the value of donations, the overall value of research grants and other tax-exempt benefits that come from being a charitable, the market value of the reputation of being charitable, none of that is in there, just the quantifiable numeric values.

Mr. STARK. I am just guessing here, but were the real estate and sales taxes the largest?

Ms. KANE. Yes. The real estate was the largest.

Mr. STARK. By far?

Ms. KANE. By far, yes.

Mr. STARK. So, that in effect, in the community, if you let the Federal income tax go away, which I don't think is very significant, if the local community, for example, were to apply real estate taxes to the institution, and then give them a voucher for every local resident that they treated who was indigent, say, and if they got enough vouchers, they could pay their real estate taxes. We would have a little bit more accurate way to measure what we in our re-

spective communities were getting out of these hospitals, would it not?

Ms. KANE. It would help to be able to at least quantify the value of the real estate taxes. I just want to point out that when local tax authorities do challenge a hospital's tax exemption, as in Pennsylvania, what they ask for instead of vouchers for free care, is they ask for dollars to support highways and schools, so it doesn't get translated back into health care.

Mr. STARK. Okay. I suppose that happens with all of our real estate taxes, and squeaky wheel theory that I am sure you all teach in your various Ph.D. courses. Mr. Lee, are you acquainted with the Maryland Hospital Plan at all?

Mr. LEE. I am not sure what you are referring to, sir.

Mr. STARK. Well, Maryland has, I believe now, a unique system for reimbursing hospitals that I think would put many of your fears or your concerns to rest. Free advice, it is worth what you pay for it. We did have the California Hospital Association Board of trustees here to review what they do in Maryland. It probably would help California, but it is something you might want to take a look at just to get an idea of how some of the concerns that you have might be addressed. I guess this is just in the way of disclosure here, but do any of you have either a financial interest in, or a large consulting contract with any for-profit plans, any large ownership, contractual—you sit on any boards? None of you?

[No response.]

You are all pure as the driven snow. Good.

[Laughter.]

Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you very much. Mrs. Johnson, would you like to inquire?

Mrs. JOHNSON. Just briefly, what do you know about another aspect of the issue of charity care and nonprofits? One of the key differences between a nonprofit and a for-profit is that the for-profit is more agile and can simply close up and move out if the charity care is overwhelming their bottom line. We have some indication, at least I have seen some evidence that for-profits are doing better in part because they have rebuilt hospitals in the suburbs and left the inner cities.

I would guess that part of the reason they have done that was because of the overwhelming concentration of charity care in the inner cities, though I don't know that. What do you know about this subject? Are mergers, are for-profits moving to avoid high volumes of charity care and leaving for-profits with greater charity responsibilities? Anyone of you who would like to respond that.

Mr. GINSBURG. Well, actually, I could say from our visits to communities around the country, we see both for-profit and nonprofit hospitals focusing their expansions in suburbs where there are large numbers of privately insured patients. It seems as though there are market incentives out there, and they are being responded to by both for-profit and nonprofit hospitals in many cases.

Mrs. JOHNSON. With no differentiation? There is no predominance of one versus another in their movement?

Mr. GINSBURG. Well, I am sure there is a differentiation. In a sense, I think the shareholders of a for-profit company wouldn't for-

give them if they located new hospitals in areas where most of the people were uninsured. Some nonprofit hospitals that have good assets have that option of focusing more on their mission to provide care to the uninsured and other community services.

Mrs. JOHNSON. Anyone else? Ms. Davis?

Ms. DAVIS. If you look at the major provider in inner cities, those are either academic health centers or public hospitals. Historically, that has been the case, and they are the ones that wind up with large proportions of uninsured patients, large proportions of Medicaid patients. They are the dominant provider in those communities.

Mrs. JOHNSON. Anyone else care to comment? Yes, Dr. Herzlinger?

Ms. HERZLINGER. There is an interesting example of the hospital system in Milwaukee, a nonprofit hospital system which is the main provider of charity care in the inner city. It has formed a for-profit joint venture with its cardiologists to open a heart hospital in the suburbs. The cardiologists control the majority share, so they are, as you so aptly put it, nimble and responsive to the market. The hospital owns the minority—and the rest of the community, the minority share, and the hospital uses—the nonprofit hospital uses the profits from its for-profit venture to subsidize charity care in the inner city. I think it is an important and an instructive example.

Mrs. JOHNSON. Thank you very much. Dr. Ginsburg, just one comment on your technology issue. You know, the current payment system rewards expensive technology for diagnosis or treatment. It does not reward systemic technology that would reduce overhead costs or improve quality or eliminate duplicate care. So, I think right now we see technology as a big cost driver, but it is because the system is selecting the most expensive technology, and the technology most easily subject to overuse.

Mr. GINSBURG. That is right, and I think we have a problem just as far as medical services of inadvertently overpaying for some services, usually the newer ones where there are still productivity increases and underpaying the others. When it comes to things like information technology, which I believe has enormous potential to improve care and quality, often the business case is negative, that because of the fee-for-service payment system, often what hospitals or physician practices can do to avoid complications and errors hurt them financially rather than reward them.

Mrs. JOHNSON. Thank you, Mr. Chairman, for your courtesy.

Chairman HOUGHTON. Thanks very much, Mrs. Johnson. Mr. Kleczka?

Mr. KLECZKA. Thank you, Mr. Chairman.

Ms. Herzlinger, I happen to represent Milwaukee.

Ms. HERZLINGER. I know that.

Mr. KLECZKA. I think your analysis of what is going on with the boutique heart hospitals is not really accurate. In fact, since they are investor owned, there is not that much coming back to the hospital. It is going to the physicians who are the owners in part of the specialty hospital.

I should point out that we have two in Milwaukee, and I do not think it is a model to brag about for a profit hospital care, because

what they are doing is not only from the nonprofits but also the for-profit hospitals, they are taking or cherrypicking not only the patients, but they are also taking out of these hospitals that provide charity care one of the big profit centers, and that is the heart.

I am happy to relate to you that both are doing very poorly in Milwaukee, and, in fact, they are having a problem getting patients and are today they are running specials. You can get a Magnetic Resonance Imagery (MRI) for $49.95. So, let me just say for those of you who shop at Kmart, come to Milwaukee and, even though you do not need one, we can get you a real cheap MRI for $49.95. So, you all come down, hear?

[Laughter.]

The problem I am having with this hearing is that we need this to find out more information on what is going on, and I guess that is fine, if the Committee were consistent on that. Know full well that last week we passed a tax bill which contained a $9 billion tobacco buyout for the tobacco farmers of the country, and this Committee never met and had a hearing on it. The full Committee never had a hearing on it, so we passed this blindly with no input from the public and it went through Congress—it went through the House, anyway, by a vast margin.

Today, we read in the Washington Post that the bulk of that $9 billion is going to go to the big, big, big tobacco producers, and the Ma-and-Pa farmer who has 10 acres or so of tobacco, they are going to get $1,000 a year. For the Chairman to come here and say, gosh, we have to do this, the Committee is so knowledgeable, we were not last week when we took $9 billion of your money and just dumped it down the ashtray.

I have a real problem, Mr. Chairman, with equating health care with buying a car, because when I bought my Jeep, I could kick the tires, but when I went for my colonoscopy last week, I couldn't kick my colon. I had to have someone who is an expert in that to do that, Dr. Herzlinger, so when you say that we have to provide the system in the country for health care consumers to get things cheaper, well, we have that for consumer goods. I can go buy a Digital Video Disc (DVD) for $39.95, pretty cheap, but where am I buying it from? I have to go to Kmart for that, who buys DVDs by the zillions from China and sells them cheap. However, if I go down to my local electronics store two blocks away from home, I am going to have to pay $129 for the same DVD because they don't volume purchase and things of that nature and that is our current health care system.

Ellen Bradley from Milwaukee has 5,000 employees and they go either to the hospital and the health care system and say I want to make you a deal, I have 5,000 people I want insured. Or they can go to a third-party insurer like Blue Cross or Aetna. That is where I as the consumer get my deal, through volume purchasing. I do not think we are going to see this through this much-touted HSA problem. In fact, it is going to probably add to the bad debts for the hospitals because until I have my account established, my high deductible has to be paid out of my pocket. For someone who is living on the edge and, you know, bought that car that you talked about so cheap, the Impala that they are giving away, they are not going to have money after they pay their Impala monthly

payment to pay the hospital the $2,000 for the one visit or one episode. What we are looking at is destroying the employer-based insurance system of the country, and we, my friends, are going to live to regret it.

Now, if, in fact, we want nonprofit hospitals to do things on the cheap, as Dr. Ginsburg pointed out—and it was disputed by the Chairman, but I do not believe the Chairman or agree with the Chairman—a lot of the hospital costs and doctor costs are related to new technology, which we all want. So, we are going to say to the nonprofits, We want you guys to do it on the cheap so you can give more health care away and forget the new MRI because you should not be having that because you are billing these patients as Dr. Herzlinger said in her statement—in fact, what she referred to in the statement is price gouging of the uninsured. Well, that has not been proven by any of the panelists today. It is a nice thing to say. Again, I have to refer you to the article I put in the record, and this was the one I asked you to read, and it is a Business Week article, and it is entitled "Making Hospitals Cry 'Uncle.'" If you ask me, it is not the nonprofit, tax-exempt status that is up today for a hearing. It is this article here which talks about a large contributor to the Republican Party and what he is doing to hospitals by grabbing them by the neck and shaking them until they call "Uncle." Thank you.

Chairman HOUGHTON. All right. Uncle Ryan, would you like to——

[Laughter.]

Mr. RYAN. What was the question? I, too, represent Milwaukee, Milwaukee County, seven suburbs in Milwaukee and I would argue that there is a different story behind these specialty hospitals. The MRI center in question, they are providing a service to the Milwaukee area residents, same MRI, same General Electric MRI device, same kind of skilled MRI radiologists, and they are doing it at lower cost. They are actually on radio and television saying, "If you want an MRI and you want it today, if you need it, or you want it the next day or the day after, we will give it to you instead of having to have the long waits that you have at hospitals, and we will do it at a fraction of the cost."

Mr. KLECZKA. Will the gentleman yield?

Mr. RYAN. So, I only get 5 minutes, so, no, sorry, Jerry, not this time.

Mr. KLECZKA. I will tell you the rest of the story when you are done.

Mr. RYAN. Okay. The point is that that is injecting competition in the marketplace, and those people in the Milwaukee area who have these consumer-directed plans are actually saving money. What we are finding with HSAs, one of our big Milwaukee insurance companies that is selling these things has shown that 42 percent of the people who bought their HSAs, many of whom are from Wisconsin, are people that did not have health insurance before. We are finding that people care about cost because they now have products that allow them to save money, and then we have competition in the marketplace where we are getting the same quality or better quality delivered to people at a faster time frame at lower cost. So, this form of competition is actually working, and we see

it in Milwaukee. I did not want to give a speech. I wanted to ask a question.

Ms. Davis, I wanted to ask you a quick question, and then Dr. Herzlinger. You stated that other countries had a greater role for the government in establishing hospital budgets or pay rates. Moreover, other countries have done more to rationalize costs than the United States has, as you have mentioned. You know, I have seen so many cases, in the United Kingdom, in Canada, where we see these global budgets in place, we see rationalized costs, but they are accompanied with long waiting lists and higher mortality rates and lower-quality care. Could you comment on that?

Ms. DAVIS. In terms of waiting lists, you are right. Waiting times for elective procedures in the United Kingdom are much longer than in other countries. They are longer in Canada, and the United States is very low on waiting times for surgeries that are elective procedures.

In terms of quality and outcomes, we just recently released a report that was put together by an international working group on quality indicators, and they looked at 21 different quality indicators across the United Kingdom, Canada, Australia, New Zealand, and the United States. The United States is kind of in the middle. It is better on some things, and worse on other things. We are the best on breast cancer of those five countries and 13 percent better than the United Kingdom. On 5-year survival rates for kidney transplantation, Canada is the best, and the United States is the worst. Canada is 14 percent better than the United States.

It is a narrow difference, 10, 15 percent. We are usually in the middle, better on some things, though not on everything. Certainly in terms of convenience and waiting time for hospital care, we are better. On waiting times for physician care, we are actually not better. The United States and Canada are toward the bottom. In other places, you can get physician care the same day if you are sick and need care. Here, you wind up waiting a week, 2 weeks, to get——

Mr. RYAN. Well, is it not true that the average waiting time in Canada is 6 weeks for primary care and 7 weeks for a specialist on top of that?

Ms. DAVIS. The U.S. waiting time for physician appointments are long also, which is surprising to me——

Mr. RYAN. In HMOs or PPOs or every instance?

Ms. DAVIS. Well, for most, the non-elderly population, they would be in managed care.

Mr. RYAN. Okay. Just because I am running out of time, Ms. Herzlinger, I want to ask you, you know, I think one thing that we are all probably agreeing on here—and Congressman Stark and I had a hearing on this in our other Committee, the Joint Economic Committee—is transparency on price. I think that is something that everybody here, every witness from all different sides of this debate spectrum have agreed, let's have transparency on price. That is something that I think we can get consensus on, and I have always said to my hospital friends that either they are going to come up with a way of doing it or, unfortunately, the government is going to have to do it for them. I would hope that the industry would figure out a way of doing it. My question to you, Ms.

Herzlinger, is: does the current lack of price transparency benefit hospitals? Since this is the tax status hearing, how does that play into their hands on pricing strategy, if it does at all? Could you comment on that?

Ms. HERZLINGER. I think lack of transparency in a market always hurts consumers. If people do not know what something costs, they are not going to be good shoppers and when they are not good shoppers, we have misallocation of resources. So, whether it hurts or helps hospitals, I do not know, but it certainly hurts consumers. If I needed to have a mastectomy, I would know more about my tomato sauce, my car, my pantyhose, than about the quality and the cost of the surgeon and hospital in which that mastectomy is to be done right now.

Mr. GINSBURG. If I could add something, I am certainly in favor of consumers having as good, accurate, and accessible price information as possible when they have incentives to choose lower-cost providers. We have to realize that in most markets, there is a lot of concentration on both the insurer and the hospital side. This is oligopoly and oligopsony, and it is not clear that actually announcing the results of negotiation between large insurers and hospitals is necessarily going to be better for the consumer. You know, if you think of cartel theory, public prices, it is a way of having—it facilitates the workings of a cartel. So, we need to be very careful that while we do want to provide a lot of relevant price information to the consumers, we do not want to also broadcast it around to make negotiations come out differently.

Mr. RYAN. Thank you. That was insightful.

Chairman HOUGHTON. Thanks, Mr. Ryan. Mr. Sandlin?

Mr. SANDLIN. Thank you, Mr. Chairman, and thanks to each of the witnesses for coming today. Dr. Kane, in reviewing your testimony, do you think that the cost of the preferred tax status of the nonprofits outweighs the benefits that those hospitals provide to the communities?

Ms. KANE. I think I mentioned we do not fully know how to value some of the benefits, some of the community benefits that hospitals do provide, including stand-by capacity, or some of the things that——

Mr. SANDLIN. Stand-by capacity and, of course, saving people's lives and treating people and taking care——

Ms. KANE. Well, nonprofit and for-profit hospitals save people's lives, so it is pretty hard—I hope.

Mr. SANDLIN. Well, my point——

Ms. KANE. It is a little hard to——

Mr. SANDLIN. My point is——

Ms. KANE. Just attribute that to tax-exempt status.

Mr. SANDLIN. My point is this: it is not all about business and dollars.

Ms. KANE. Absolutely.

Mr. SANDLIN. It is about treating people in health care; isn't that correct? That is the first obligation. Isn't that right?

Ms. KANE. Both for-profit and not-for-profit hospitals do treat people and hopefully do the best they can.

Mr. SANDLIN. Now, the Tax Code, I was looking at the 501(c) requirement, and it says that the hospitals have to provide a

health benefit to the community at large, these nonprofits. Is that correct?

Ms. KANE. Yes, they are expected to provide a health benefit, which is about the same thing that a for-profit does.

Mr. SANDLIN. I understand that. My question to you is: does a 501(c)(3) nonprofit, are they required under the law to provide a health benefit to the community at large? That is my question.

Ms. KANE. Well, I believe so. I am not a lawyer.

Mr. SANDLIN. Okay. Thank you. Now, these hospitals are providing a health benefit to the community at large, are they not?

Ms. KANE. The nonprofit and the for-profits are both providing a——

Mr. SANDLIN. My question is: are the——

Ms. KANE. Health benefit to the community at large.

Mr. SANDLIN. Nonprofits providing a health care benefit to the community at large as required by the law? That is——

Ms. KANE. I hope so.

Mr. SANDLIN. Thank you. So, they are following the law, aren't they?

Ms. KANE. Again, I think you are asking me the question in a way that is probably inappropriate——

Mr. SANDLIN. No, ma'am. Here is my——

Ms. KANE. In respect to the issue around tax exemption.

Mr. SANDLIN. My question—no. My question is: they are following the law, are they not?

Ms. KANE. As far as I know. I think some hospitals do not necessarily follow the law, but most do try to provide a health benefit to——

Mr. SANDLIN. Do you think that nonprofit hospitals should provide a specific amount of charity care?

Ms. KANE. I think they should provide a specific amount of community benefits, as more specifically defined than is currently defined in the Federal law.

Mr. SANDLIN. Okay. Now, I have noticed that you have used some of your research, it says, and the materials we have to challenge the tax-exempt status of hospitals in Texas and Massachusetts and Idaho and Virginia, Ohio, Maine, and New Hampshire. Is that correct?

Ms. KANE. I am sorry. What was the question?

Mr. SANDLIN. Have you been involved, have you used research to challenge the tax-exempt status in those States that I listed?

Ms. KANE. I have not actually been the challenger. Usually, the Attorney General or a local tax authority is the challenger, and I am hired as an expert witness to assist in those challenges.

Mr. SANDLIN. So, basically you are an advocate for challenging the tax-exempt status——

Ms. KANE. No. I am usually the expert witness for those who have already challenged the tax exempt status of a hospital, in general because even though it is providing health care for the good of the community, they have a bad habit sometimes of telling people who do not pay full charges or were not insured that they cannot get care in their emergency room until they are really, really, really sick and that is when they get challenged.

Mr. SANDLIN. Okay.

Ms. KANE. There are some pretty egregious examples of that. I hope you are not trying to——

Mr. SANDLIN. Well, that is a charming——

Ms. KANE. Defend those.

Mr. SANDLIN. Story, but that was not my question. Now, you said that you are not an advocate for challenging the tax-exempt status of the hospitals, so could you tell me, in all the areas that you have worked to support or maintain the tax-exempt status of a hospital? What States have you done that in?

Ms. KANE. There usually are not challenges to support the hospital's tax-exempt status.

Mr. SANDLIN. Have you—I did not—have you taken a position contrary, have you taken a position on the other side of the issue to say, no, the tax-exempt status should be maintained in any State?

Ms. KANE. I have written about hospital tax—the whole article that I wrote that is cited in my testimony talks about the hospitals that do maintain their tax-exempt status through the virtue of providing charity. So, I do believe that most of my work is on measurement and reporting fact, and then——

Mr. SANDLIN. My question is——

Mr. MORRISON. If it happens to be useful to those who make a challenge, that is who calls me.

Mr. SANDLIN. Well, thank you again, and you have a nice report. Here is my question: you said that your research has been used as an expert witness to challenge the tax-exempt status of certain hospitals. Has that research been used or have you been an expert witness on the other side to support nonprofits hospitals? In what States would that be?

Ms. KANE. No, I have not.

Mr. SANDLIN. Okay.

Ms. KANE. Generally, people do not challenge hospitals if they think they are——

Mr. SANDLIN. That was not my question——

Ms. KANE. Already acting charitably.

Mr. SANDLIN. I think we understand what you are saying. Now, in Texas, are you aware of what the Texas law is on the requirement for charitable——

Ms. KANE. The Texas law was passed partly as a result of the challenge that I was involved in in Texas back in 19—somewhere between 1989 and 1991 or 1992, I believe.

Mr. SANDLIN. In 1993—well, the first I think was 1985 on indigent health care. In 1993, it was SB 427 and that requires charity care and government-sponsored indigent health care provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding Federal income tax, or charity care and community benefits are provided in a combined amount equal to at least 5 percent of the hospital's or hospital system's net patient revenue. Do you feel like that is an adequate amount?

Ms. KANE. I felt that was a fair law. They had to define "community benefit" in a way that leaves out things like Medicare contractual adjustments and medical bed——

Mr. SANDLIN. One final question. I notice there are lawsuits filed against East Texas Medical Center Regional Health Center in Tyler, Texas. Are you an expert witness or consultant in that particular litigation?

Ms. KANE. No.

Mr. SANDLIN. Have you been consulted or talked to in any way about that particular litigation?

Ms. KANE. No.

Mr. SANDLIN. Did you know that system provided $91 million in charity benefits in 2003 and will pass $100 million in 2004?

Ms. KANE. I am sorry. I did not hear what you said about the——

Mr. SANDLIN. I said were you aware that—you do these studies, and I just wanted to know if you were aware that that system provided $91 million in charity care in 2003 and will pass $100 million in 2004.

Ms. KANE. No, generally the data I get has to be nationally available, and that may not be something that is in one of my data sets. It is pretty hard to get that data unless you are involved in a lawsuit in Texas.

Mr. SANDLIN. Okay. Well, thank you for that. It just seems to me, Mr. Chairman—I am finished rather than attacking the hospitals, we should focus on coverage and if we focused on coverage, we could take care of these issues. Thank you, Mr. Chairman, and thank you, witnesses.

Chairman HOUGHTON. Thank you. Mr. Johnson, Mr. Sam Johnson?

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate that. I would just like to say that we have specialty hospitals, numerous in our area, and they are all doing a great job. It seems to me that physicians do not get away from the regular hospital when they get into the specialty business. They still maintain their status with the regular hospitals. Would you think that the patient should or shouldn't have the ability to choose between a specialty hospital and a regular hospital if the physician operates at both of them? Anybody.

Ms. DAVIS. The basic problem is that there are very different profitable returns on different services. So, the real problem is that you can make so much money on orthopedic care and cardiac care, yet you can lose so much money on burn care, and neonatal intensive care. If we had a more rational pricing structure, we would not have services being skimmed off into separate hospitals. It reduces the ability to cross-subsidize both patients who cannot pay and important——

Mr. JOHNSON. Okay. Let me ask you this question: why do you think they skimmed off to specialty hospitals? Because they were not getting the service at the hospital, which mostly are not-for-profit. My view. Excuse me. I interrupted you.

Ms. HERZLINGER. Not at all, Congressman Johnson. I think that the specialty hospitals, just like specialization in the rest of the economy, make things more efficient and more effective. That is why General Motors spun off Delphi because it couldn't do everything. There is tremendous data to show that the patients are very satisfied and they are lower cost.

The core problem is why do they set up specialty hospitals in heart and orthopedics owned in the Milwaukee area, to my knowledge, by the cardiologists in the area and the nonprofit charitable hospital system in the area. The reason is that we have these third-party payers who are setting the prices. Sometimes they set them too high, as in cardiology and orthopedics, and sometimes they set them too low, and sometimes they set them so that they stop the innovation, which is the key to raising productivity in the U.S. economy.

For example, Ralph Snyderman, the chief executive officer of the Duke Medical Center, innovated a new treatment for congestive heart failure. Congestive heart failure costs $56 billion. In 1 year, by focusing, by specializing on congestive heart failure, he reduced the cost by 20 percent in 1 year. The way he did it is, because he was specialized on congestive heart failure, he made people healthier. When they were healthier, they used the hospital less and they stayed for shorter amounts of time.

In a normal marketplace, this kind of innovation would reap large rewards. Ralph Snyderman lost virtually all the savings because under a large third-party system, which is not agile and not responsive to innovations, he gets paid for treating sick people and the healthier they are, the more money he loses. That is the problem with a volume-based model that says, well, the big insurer can get big discounts. Perhaps that is so. The big insurer can also stifle the innovation, which is the heartbeat of the productivity in America.

Mr. JOHNSON. Let me interrupt you. I am about to run out of time.

Ms. HERZLINGER. Sorry.

Mr. JOHNSON. I want to hear from Dr. Ginsburg as well. Thank you.

Mr. GINSBURG. Yes, I wanted to first say that I think the problem is not big insurers. It is fee-for-service payments. When you pay for delivering more care, it is never a hospitable system for excellence, for doing better with fewer resources.

I just want to say something about specialty hospitals. There certainly are cases where specialty hospitals have innovated in care, but because of our financing system, because our reimbursement rates do not adequately reflect costs—and the Medicare Program needs to pay attention to this—because of the fact that we have different insurers paying different amounts, there is a potential that the technical success of the specialty hospital could cause irreparable harm to community hospitals, not because the specialty hospital is better, but because it is agile enough to concentrate on the inadvertent incentives that have been placed in the system to treat more cardiology and orthopedics, to treat privately insured patients instead of Medicaid patients. I am also concerned about the conflict of interest that physician owners of these facilities have.

Mr. JOHNSON. Can he answer? Go ahead.

Mr. LEE. Congressman Johnson, I want to build on one other point about the issue both with specialty hospitals but also it goes to Congresswoman Johnson's question about the expansion of hospitals to suburbs, and so forth. One of the key problems we have driving hospital costs is supply driven demand. Where you have

more hospital beds, more people use them. We had in Northern California, Redding, which got a lot of attention, a Tenet hospital, it was not just an issue of its outlier payments. They were having too many people getting cardiac care, and it is because if you have docs that want to fill up their portfolio, with all due respect to physicians, people will get more care—physicians will provide more care. One of the issues we have to get to consumers is information not just about whether this hospital doing a good job or not, but are they doing the right care at the right time. That is one of the concerns that I have about specialty hospitals.

Mr. JOHNSON. Well, I will ask another question later, but it seems to me the not-for-profits are building more hospitals than the for-profits. You might answer that next time. Thank you.

Chairman HOUGHTON. All right, fine. Thanks, Mr. Johnson. Mr. Portman?

Mr. PORTMAN. Thank you, Mr. Chairman, and I thank the witnesses today. We have had a very interesting dialog about health care, haven't we? We have gotten to talk about costs and technology and its challenges as well as its opportunities. We have talked about pricing and transparency, and I do take some comfort, Mr. Chairman, in the fact that at least this panel, and I believe the panel that I am sitting on—perhaps there is not a consensus on this, but a majority of us, at least, seem to be focused on the fact that more transparency and more information will make not just a more efficient health care system, but a higher-quality health care system and that is encouraging. I do think that is a general direction that we should be able to move on a nonpartisan basis. Then the final issue is the tax-exemption issue, and they are all related, of course. Since that seems to be more of the focus of the hearing, let me focus my questions on that.

I will start by saying I represent the greater Cincinnati area. We have three nonprofit health care networks who do a terrific job in our community. They are all involved in charity care, uncompensated care, but also community benefit. They are also businesses, and they are run more like businesses today than they were 10 years ago, even than they were 2 years ago. As a result, they have gotten over some very significant financial challenges. Mr. Lee talked about excess bed capacity and so on, and, we have gone through a pretty aggressive managed care revolution really in Cincinnati and back and forth. My point is they are businesses and they have a bottom line, and they must compete, and they do.

Having said how important it is that they provide that community benefit—and it is—I also think it is appropriate for us to review and clarify the rules. We are basing most of our discussion today on, incidentally, a 1969 IRS ruling with regard to what, in fact, is a community benefit, which was a change from the charity definition and you know, probably once every—what would that be—35 years, it is time to review where we are, not that that has not been done periodically in the interim period, but I think it is appropriate that we talk about where we are.

So, my question would be whether this panel would have any specific recommendations as to what the standard ought to be. Do you believe the community benefit standard is appropriate, again, dating back to 1969? Do you believe that there should be more spe-

cific standards? Which is something Dr. Kane alluded to earlier and if it is all right, I will just start with Dr. Herzlinger and go across the panel. The mother of Captain Herzlinger.

Ms. HERZLINGER. Also Dr. Herzlinger, my daughter. I think businesses provide community benefits as well. They do provide employment. They pay taxes into the community. Nonprofit hospitals not only have tax subsidies; they also have capital market subsidies. They are entitled to issue municipal debt, which businesses cannot, and raise the cost of capital elsewhere in the economy.

When we talk about community benefits, I think it is very important to identify those community benefits that are unique to nonprofits and that for-profit businesses, which, after all, are the cornerstone of our great economy and our great country, also generate.

Mr. PORTMAN. Thank you. Ms. Davis?

Ms. DAVIS. I think it is hard to quantify all of the community benefits, like the value of stand-by capacity. So, when you set an explicit quantitative goal, you wind up focusing on charity care because it is easier to measure. So, I think there are some problems with trying to set a specific quantitative goal.

I do think one could work on better practices, for example not charging American uninsured patients more than the discounted rate you would give to an insured patient; not having certain kinds of collection practices, like liens on homes; and publishing the availability of charity care. So, I think that is kind of the area where I think the best improvement could be made in the near term.

Mr. PORTMAN. Interesting suggestions. Just as an aside, the three major nonprofit networks in Cincinnati have just come up with a draft billings and collections principles and guidelines statement which they shared with me yesterday. In fact, I was going to ask it be made part of the record later, if I could ask unanimous consent, Mr. Chairman, to make it part of the record. It is currently being subject to a comment period, but it gets at those very issues, Ms. Davis, you talked about, including collections. Mr. Lee?

[The information follows:]

DRAFT UNTIL PUBLIC COMMENT PERIOD ENDS 7/1/04

Billing & Collections Principles and Guidelines for Low-Income, Uninsured Patients

Principles

All patients should be treated fairly, with dignity, compassion and respect.

Hospitals have a financial responsibility to seek payment from patients in cases where the patient does not qualify for charity care and where the patient's income or other assets clearly indicate the ability to pay for the health care services provided.

Each hospital should have clearly articulated, understandable financial assistance policies consistent with its mission and values, and which underscore the hospital's commitment to provide financial assistance to low-income patients.

Financial assistance policies should be clearly communicated to patients and must be applied consistently to all patients.

Financial assistance policies should apply to patients who cannot pay for any or all of the care they receive, and should balance the patient's ability to pay with the hospital's need to be fairly compensated for services rendered to ensure its on-going financial viability.

Hospitals should assist patients with enrolling in Medicaid and other government—sponsored programs.

Debt collection policies of the hospital and its debt collection agencies and attorneys must reflect the mission and values of the hospital.

Financial assistance policies do not preclude the patient from personal responsibility. Patients must communicate their financial situation to hospitals, must work together with hospital staff to receive financial relief, and must be expected to meet their financial responsibility based upon their ability to pay.

Hospitals will not be able to reinvest in plant, equipment and new technologies to continue to provide the highest quality of care without being compensated for their services. Financial assistance from hospitals must be complemented by efforts of government, employers and others to expand access to health care coverage for all Tristate residents.

Financial Assistance Eligibility

Each hospital should maintain, and update as appropriate, written financial assistance policies for low-income, uninsured patients including those eligible for charity care.

Absent regulatory prohibition, hospitals should develop discount programs for low-income uninsured patients who do not meet Federal Poverty Guidelines (FPG) to qualify for charity care. These discount policies should be reevaluated periodically.

Hospitals should work with patients who do not qualify for charity care to establish extended payment options including low interest loans that are appropriate given the patient's income and assets. Consideration should be given to prompt payment discounts and other means of relieving financial pressure on self-pay patients.

Hospitals should ensure best efforts to apply policies consistently to all patients, and hospitals should clearly define the type and scope of services eligible for assistance.

Hospitals should assist patients in determining eligibility for government-sponsored aid.

Hospitals should continue to provide financial assistance to patients who have exhausted their insurance and who exceed financial eligibility thresholds for extraordinary medical costs, although hospital financial assistance is not a substitute for employer-sponsored, public or patient-purchased insurance.

Communicating Financial Assistance Eligibility

All financial assistance applicants should be treated with dignity, respect and with cultural sensitivity. Free interpretation and translation services should be made available as necessary.

All patients regardless of income level or payment status (i.e. insured, Medicare, self pay) will receive access to the same information regarding services and charges.

Hospitals should ensure that patient financial services personnel and financial counselors are fully trained on the hospital's financial assistance policies and can communicate those policies clearly to patients. Receptionists and switchboard personnel should be able to direct callers to hospital staff trained to provide financial assistance.

Communications to patients regarding financial assistance should be written in reader-friendly terminology and in a language the patient will understand.

Financial assistance policies must clearly state eligibility criteria and the process used by the hospital to determine whether a patient qualifies for financial assistance. Eligibility requirements related to FPG should be clearly enumerated for patients, and patients should also be told how assets may be used in determining eligibility for financial assistance.

Hospitals should have adequate, easily visible signage in appropriate areas of the hospital (i.e. Emergency Department, Admitting/Registration) informing patients and their families of the availability of financial assistance. Signs should include brief instructions about how to apply for financial assistance including contact information.

Information regarding the availability of financial assistance should be included on hospital bills including who to contact to begin the eligibility determination process.

Patients should be clearly informed about their obligations to complete eligibility documents and to provide financial documentation as necessary, as well as potential financial obligations they may incur.

When applicable, patients should be referred to an enroller to apply for Medicaid or similar programs to assist in offsetting some or all of the patient's financial liability and to ensure that the hospital is fairly reimbursed for its services.

Hospitals should share their financial assistance policies with appropriate health and human services agencies and other organizations that assist such patients.

(The financial assistance and communications guidelines listed above apply to a hospital's treatment of patients seeking charity care, financial assistance, or discounts, as applicable. To receive such assistance, patients must comply with hospital financial assistance application requirements, including providing documentation as needed. Patients must also cooperate with hospital staff and provide needed information in a timely manner to enroll the patient in Medicaid or other programs as required.)

Collections Guidelines

Hospitals will provide their mission statement and their billings and collections guidelines to their collection agencies and attorneys, and hospitals will secure their agreement to adhere to the same high standards incorporated in the hospital's policies. (Collection agency is defined as an outside agency engaging in bad debt collection services on behalf of a hospital as opposed to an outside agency contracted to manage the hospital's day-to-day billing activities.)

No collections effort will be made by the hospital or its collection agency for patients who have completed the financial assistance application process and established their eligibility for charity care. If such a patient is mistakenly billed, hospital staff will apologize for their error and correct the mistake.

Legal action, including the garnishing of wages, may be taken by the hospital only when there is sufficient evidence that the patient or responsible party has the income and/or assets to meet his or her obligation.

Hospitals will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.

If a patient is cooperating with an agreed-upon extended payment plan to settle an outstanding bill with a hospital, the hospital should not send the unpaid bill to a collection agency if the hospital is aware that doing so may negatively impact the patient's credit rating.

(The above guidelines apply to a hospital's collections practices. However, patients who are financially obligated to pay for a portion of their care must cooperate with the hospital on establishing the best method of payment and then demonstrate good faith efforts to abide by that agreement.)

In conclusion, these guidelines largely reiterate current policies and procedures of GCHC member hospitals. However, these guidelines may require some members to enact changes in their policy, which may require operational changes including, staff training, changes on invoices, contract revisions with collection agencies, and so forth. The Greater Cincinnati Health Council endorses these guidelines and encourages its acute care hospital members to ensure that their billing and collections policies are consistent with these guidelines as soon as possible.

Mr. LEE. Also, Congressman Portman, California hospitals have come up with the same set of standards around billing practices for the uninsured. The only thing that I would add that is easily quantifiable is how nonprofit hospitals play in the market. As I noted in my remarks the concern is that hospital consolidation creates negotiating leverage that preclude insures from seeing differences in cost quality. Cost and quality do not show through because it is a take-one/take-all on the same price basis. There is a problem in the market. I am concerned with having a separate set of standards for nonprofits, and I have the exact same concerns with the for-profit systems. This is an element that I think is worth looking at.

Mr. PORTMAN. Dr. Ginsburg.

Mr. GINSBURG. My organization studies markets and the implications for consumers, but we do not take positions on policy, so I would just as soon pass on this.

Mr. PORTMAN. Dr. Kane.

Ms. KANE. I think there are new guidelines out by the IRS that correspond more closely with what Karen Davis just mentioned around practices that hospitals undertake to show that they have

a charitable intent when they are providing care. I think that is an improvement over what it was historically.

I have tried to quantify these benefits. It is difficult. It is also difficult to quantify the benefit of the exemption in any meaning—you know, without missing some large amounts of benefit that you cannot quantify. I do think the IRS is paying attention, and I think a stronger standard that allow States and local communities to play a role in what constitutes a community benefit is important. Hospitals in some States now work with their local community health agencies to say, what is important in our community for health, and if we do that, will that be considered toward our charitable status? For instance, in New Hampshire, that was part of their community benefit law.

I think there is a need to be more clear, perhaps, about what practices and what types of activities would constitute or count toward tax exemption and have some flexibility in how the hospitals choose to play that out. I think just the disclosure and the transparency of trying to do that will improve the way hospitals behave at this point.

Mr. PORTMAN. Thank you, Dr. Kane. Just quickly, Mr. Chairman, again, our three networks in Cincinnati are working, in fact, right now with our City Council, which would represent part of the population served, and with some of the health care providers for uncompensated care, health care clinics and so on, to try to determine what some of those needs are on a more regional basis and be responsive to that. The question is whether that is happening around the country. I cannot speak to that, but that is an interesting part of the equation given the fact that it is not just about Federal income tax; it is about property tax and other exemptions. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you. I am going to ask a question, and then I know Mr. Pomeroy wants to. I would like to step back a minute and move away from profits, and return on investment and community involvement and just take all those very difficult to generalize in terms of the two categories, the profit and not-for-profit. When you take a look at the cost structure of medicine, you want to have the toughest, most able, most precise financial people looking to make sure that the equipment is there, the care is there, the pricing is right. You would sort of instinctively go to the for-profit institutions.

Yet at the same time, there is another element in the not-for-profit, which is community involvement. People feel part of the hospital. They want to play a part in the whole overall medical element in the community. They feel it is part of them and I don't know why there is any inconsistency in not having a very sharp, driving, cost-conscious direction of a nonprofit hospital versus the profit hospital. Maybe you would have some comments to make on that.

Ms. DAVIS. Well, I think one of the basic differences in just what motivates nonprofits versus for-profits—and it is something I happened to look at 35 years ago in an economics doctoral dissertation—is they are motivated to be the best, to be the best equipped, and often to be the biggest, and, therefore, they will do things that do not make sense to a for-profit hospital because something they

do may lose money. You have got the very best burn unit. You have got the very best neonatal intensive care unit. You do the best research. You are there for the community and always known as, when anything really bad goes wrong, this is the go-to place that leads nonprofit hospitals to try to do things, even if they lose money.

Now, in the past, they were able to cover that because they could cross-subsidize it out of charges to privately insured patients. As that has come down relative to costs under managed care, they are less able to provide those kinds of services. For the most part, they are the ones that will do things that we as a society want done but that are not profitable. I used the example of a major fire in a nightclub. Those burn patients went to certain hospitals, and those hospitals provided care. They are not going to make money on those patients. They are going to lose a lot of money on those patients. We all want those patients taken care of. That is the sort of thing that a nonprofit will do because they take great pride in having responded to that community emergency and were there at a time when patients need them. Obviously, they get some publicity out of it in local papers, and it helps their image as an institution. That is one of the reasons the nonprofit nature of this industry is so important.

Chairman HOUGHTON. If I could just sort of cut in here a minute, to flip my argument, if you take a look at many of the corporations in this country, they are enormously generous in terms of what they do and contribute into the community. So, I just do not understand the consistency here. Maybe you would like to discuss this.

Ms. HERZLINGER. Well, on the for-profit side, clearly in a well-managed, socially responsible corporation, its aim is to maximize the return for the shareholders within the norms of society. So, given a nonprofit and a for-profit, the for-profit aim is clearly to be as efficient as possible, and for-profits, especially if they are publicly traded, are much more transparent than nonprofits. I can get the financial statements of the Hospital Corp. of America (HCA) just by flicking on my computer. I would have a great deal of difficulty getting comparable statements for nonprofit hospitals. That kind of transparency in the market is an incentive for efficiency. I think the fair thing to do is to measure the costs and quality of both of them and let people make their own decisions about which ones gives them the best value for the money.

Chairman HOUGHTON. That is difficult when you are in a small community. Would you like to add something?

Mr. GINSBURG. The perspective I would like to point out is that nonprofit hospitals today account for, I think, upward of 85 percent of the beds. They are the core of the hospital system. This percentage has been quite stable over time, and it seems as though, this is a country where not-for-profit hospitals are the norm. I think the major success that for-profit hospitals have had has been, first, in areas where there has not been a lot of local resources to support the development and expansion of nonprofit hospitals. So, in a sense, they have provided capital and I think that some of the for-profit companies have been skilled and effective at identifying failing not-for-profit hospitals that are failing because they are not

managed well and purchase them and manage them well, and then often sell them back to a nonprofit entity. We have to realize that the nonprofit hospitals have this very dominant position. Whether it is the tax-exempt status, whether it is people's comfort, whether it is their philanthropy that leads to it, they are the central system.

Chairman HOUGHTON. All right. Does anybody have any other comments? If not, then we will go on.

Mrs. JOHNSON. Mr. Chairman.

Chairman HOUGHTON. Yes?

Mrs. JOHNSON. I thought you were closing this panel.

Chairman HOUGHTON. No, no. Go right ahead because I wanted to ask Mr. Pomeroy—go ahead, please.

Mrs. JOHNSON. I will not be able to stay for the second panel, but I will review the testimony. I want to mention something that has come out of this panel, although it is not central to your responsibilities in testifying here. Ms. Davis, you mentioned the stability that Medicare has provided to the health care system. I would say that that is absolutely no longer true. You look at the physician payment law. Talk about creating instability. It is astounding. You look at our ability under Medicare to reimburse accurately, and if you take the newly proposed outpatient and inpatient reimbursements—these are new regulations. They are precipitated by the big increases we provided in the last Medicare bill and by the census automatic action every 10 years, and you go through what is the interaction between the census redefinitions, the increases we gave them, the this is and the that's and the other things. When I ask the experts, who have spent their lives on this, "what is the outcome? how many of the hospitals in the rural areas that we gave big increases are going to get those increases?," they cannot tell me. When I ask them, "what is going to be the impact on these small urban hospitals that, frankly, are most disadvantaged in the reimbursement system?" they cannot tell me.

How can I make policy when we fight for a 4-percent increase for hospital reimbursements, and then we do not know whether they get them. My hospitals came in last week and documented that for the first time under Medicare, in spite of the big increases that we gave, the work we did on Indirect Medical Education (IME), on market basket, the first time we have ever given full market basket 2 years in a row, every single hospital in Connecticut is going to get an absolute reduction. A reduction. When their malpractice premiums are zooming, when their nursing costs are going up, when their technology costs are going up, and so on and so forth.

So, what drives me—and I am going to be looking at these pricing issues. I want you to give me anything you know about what we should do about how we price in Medicare, because every aspect of the system is wrong. You cannot set a price and keep it for 20 years. Volume increases; it should be declining. What should we do about that? What should we do about these special services? I mean, ironically, we have no cost base. We do not know what anything costs. We have an arbitrary base that we set in a certain year, and we have adjusted it by inflation. This is no way to run a railroad. Whether it is hospitals, whether it is technology, whether it is this, whether it is that, you know, we are—just when you adopt a transfer policy and you reduce benefit for short stays in a

system based on averages, this is a travesty. It is a travesty of logic and it is a travesty of fairness to the hospitals.

So, whether it is doctor payments, whether it is hospital payments, whether it is boutique hospital payments, whether it is surgery center hospital payments, we do not know what we are doing. The terrible proof is that this new regulation that has come out, after the biggest increases we have ever passed across the board, the first time we have just said the whole rural system does not work because we cannot deal with low volume so we are just going to increase payments, knowing that it costs more for low volume. This is—I mean, I cannot tell you. There is no logic. There is no structure. There is no cost basis from which we can work. In the oncology area where I am absolutely insisting that practice expense bear some reality to practice expenses, I am being told, "why should we do it there when we routinely reimburse at 70 percent of practice expenses for everybody else?" What a bankrupt logic. What a quick way to destroy the quality of health care.

So, I am very interested in this nonprofit/for-profit, who is getting paid to provide uncompensated care. To think that Medicare payments are stabilizing our health care system is to put your head in the sand. I am sorry, but in every sector we are destabilizing the system, eroding quality, and driving the development of boutique hospitals and so on, in my personal estimation.

We do not have time to go into all that, but I invite every one of you to work with me on how do we change the way we price in Medicare. Because if we do not, we will destroy community hospitals, we will drive the good-quality physicians out of the system, and, frankly, it is only because of the administration's good sense and forbearance that we haven't acted to destroy key home health providers who clearly are providing more services for less acute care patients. You would think we might want to know.

Ms. DAVIS. If I could respond quickly to that, I agree with you. Most of my focus is on the patient and what is good for the patient.

Mrs. JOHNSON. Right.

Ms. DAVIS. I did testify at the time of the Balanced Budget Act that the proposed cuts to the health care sector were simply unprecedented and much too deep. The effect of those cuts and other changes in the late nineties was to take over a 10-year period $1 trillion out of the health care sector.

Mrs. JOHNSON. Right, but it is also true——

Ms. DAVIS. So, a lot of the problems we are seeing—and you see it a little bit in my charts 3 and 5 on pages 25 and 26. Medicare cut, Medicaid cut, managed care cut, and the cumulative effect of that has not been helpful to the——

Mrs. JOHNSON. I agree that the system is far more fragile than 10 years ago. It is also true that what we did in 1997 was limit the rate of growth for the next 6 years to the rate of growth of the preceding years.

What we are seeing now, because we limited that rate of growth, because Medicaid, a publicly funded system, is underpaying dramatically, and because of managed care's pressure, we are seeing a very fragile system now, and we cannot keep our head in the sand about the inaccuracy of our payment structure any longer. So, I invite your input. I know that you are concerned about this, and

I just wanted to note that we are—you know, I see this as the first hearing in this venue, but we will be hearing these other things that are intimately related, too much for one Committee, and I invite your cooperation and input. Thank you very much, and thank you, Mr. Chairman, for your indulgence.

Chairman HOUGHTON. Thank you. With all of that good news, I now turn to Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Well, we have been at it a couple of hours, and I think so far this hearing has established that a hearing undertaken without a rational focus is unlikely to produce a clear record. That said, I want to respond to the Chairman Thomas charge that we can try to make some sense of all this. I believe that we have established in this discussion that pricing alone is not a very effective sole indicator of whether tax-exempt status for hospitals or not is being appropriately fulfilled in the exercise of their operations. Is that correct? Is that a consensus across the panel? Any objection to that suggestion? Okay.

Then let me ask you this: do you think there would be—I have seen—I used to be an insurance commissioner for 8 years. I have seen all kinds of things in terms of hospital practices, proprietary and nonprofit. I have seen some wonderful commitment to the charitable mission of these nonprofit institutions, and I have seen some exercised, on the other hand, incompetently and less rigorously.

Is there something that ought to happen, that Congress can contribute to the nonprofit hospital world by way of surveying best practices, establishing a matrix of things that might be present in an exemplary nonprofit hospital institution, not to enforce but that maybe a hearing record would contain and it might provide some guidance to hospital executives and boards of directors in terms of things they ought to be keeping an eye on to make certain they comport with what is expected of best practices within the nonprofit hospital status? Would that have some value? Let's just run right across the table and start with Dr. Kane.

Ms. KANE. I think if Congress can come to some consensus on what best practice is, other than simply providing care to the public, it would be helpful. I am not sure you can come to consensus, having just heard the debate on the panel here of the Members. I think it would be helpful to clarify what Congress thinks merits tax exemption, at least at the Federal level. It would be helpful to go beyond that and say, you know, here are best practices and how we expect you to provide those types of activities, if they are community-based activities, if they are the way you do billing and collection, if it is the way you make people eligible for charity care and at what income levels. All of that guidance would certainly help to make it more standard across the country in terms of what a citizen can expect if they do need a health care intervention in their lives.

Mr. POMEROY. So, maybe right topic as we discuss tax-exempt status, but we have to go far beyond pricing to capture maybe a solution that has value.

Ms. KANE. Pricing is not really the—not where I would go first.

Mr. POMEROY. Dr. Ginsburg.

Mr. GINSBURG. Yes, I think pricing is a different topic. I think that it really would be useful to have expressions from the Congress about what it expects hospitals to be doing for the tax-exempt status because the Congress has not spoken to this for a long time.

Mr. LEE. Congressman Pomeroy, the only thing I would add is a best practice area that Congress could make advice on is around not just what the hospitals do but how we pay hospitals. We have heard that one of the other consensuses here is a dysfunctionality in our payment system, a discussion that we need to reform. I would actually recommend to this Committee the Medical Payment Advisory Commission's (MedPAC) June report which actually talks about forward-thinking purchasing practices that is going to be the driver, I think, of changing hospitals' performance.

Ms. DAVIS. I think you have put your finger on a very good idea. We have supported a case study of exemplary hospitals, which we will be releasing in August. It started with a database on hospitals in 21 States and found those in the best quartile on efficiency and the best quartile on quality measures, risk-adjusted for different diagnoses; out of that, it identified the 30 best hospitals and did case studies on four of them.

There are certain characteristics that are common to all of those best hospitals. It has to do with starting at the top, with the chief executive officer's real commitment to quality. It has to do with something called true resource management in airlines, but it means that you listen to everybody you listen to the nurses when they say there is a problem, and you fix it. Everybody is free to speak up when they see a problem, and it gets addressed. I think that is just the beginning. That was conducted for us by Jack Meyer at the Economic and Social Research Institute. Other work in that area, whether it is on quality, efficiency, or access, would be very valuable.

Ms. HERZLINGER. I think it is very important that the Federal government insist on measures of quality by provider, by hospital, by procedure for diseases over the long term. That is what transparency is all about. That is what the American people are interested in, as well as price data. The quality data are very important.

However, I think it is very dangerous for the government to get involved in specifying the processes of care. Best practices are the consensus of the majority, but the real innovations come not from the majority; they come from iconoclastic outliers. For example, the——

Mr. POMEROY. I agree. My time is up. By best practice, I mean, you know, consensus that we ought not attach houses of people that——

Ms. HERZLINGER. Oh, of course.

Mr. POMEROY. Not at all medical——

Ms. HERZLINGER. I misunderstood. Certainly.

Mr. POMEROY. Thank you very much.

Chairman HOUGHTON. Mr. Ryan.

Mr. RYAN. Are we doing a full round?

Chairman HOUGHTON. A very quick second round, please. Go ahead.

Mr. RYAN. Okay. Let me see if I can widen the focus here a little bit from the beginning statements of this hearing. Do we have good

measurement as to the value attributed to this tax status? Obviously, I think everybody agrees we do not have that. Do we think that public value comes from this tax-exempt status? I think so. What is the measurement of that? Who knows? Is that measurement so great that the costs do not outweigh the benefits? We don't know the answer to that question. Perhaps with better available data we will get the answer to that question. It is a question that ought to be asked of all of us in the public for the public good.

I guess the question is: you cannot get away from the whole uninsured question when you talk about this. I mean, if we are talking about the system today where we have to rely on the public charity of nonprofit organizations who have to cross-subsidized in order to pick up those who do not have insurance, that is the system we are working in today. So, is this a rational delivery system within this use of this tax expenditure to get the care to those who are uninsured? Or should we try and focus on getting insurance into the hands of those who do not have insurance so that this method of redistribution and cross-subsidization is not necessary?

I would like to ask you to sort of pull that focus back a little bit and answer it this way: are we better served, quantitatively, economically, by fixing this uninsured problem we have in this country so you can focus on competition, on transparency, on making the market work? Or is the current system of using a tax expenditure on an ad hoc, individual hospital-by-hospital basis, cross-subsidizing and picking up the slack better than fixing this uninsured problem? Let me ask it that way and we will just start left to right, Dr. Kane and then to the right.

Ms. KANE. I think probably the obvious answer is it would be great if everybody was insured. This is something that I think—didn't Harry Truman suggest that? I mean, I am trying to think of how far back—I mean, it was before I was born, actually.

Mr. RYAN. We have to——

Ms. KANE. I agree that——

Mr. RYAN. Focus on direction of public policy.

Ms. KANE. Absolutely. We would love to see everybody insured in some type of universal coverage. I don't think you dare leave out the interim steps that we have in place for the safety net, because we haven't gotten there yet, and I think in 1969, the IRS and whoever set the laws misunderstood the impact of Medicare and Medicaid, thinking it would eliminate the uninsured. Guess what? They have come back.

I think we always have to be aware that, you know, until we are truly universal, we really will have people who are at risk who are not covered, and that we do need a system, a safety net for those people. Yes, absolutely, the bulk of public policy in my mind should be toward insuring everybody.

Mr. GINSBURG. It is really inconceivable that someone can be seen as having access to medical care today without having insurance and that should be the first priority. What I would say is that what we are seeing as our health care system becomes more competitive, it is becoming more difficult to continue the cross-subsidies that we have historically depended on to serve uninsured people or low-income people. As Nancy Kane says, we still have to do it, but in a sense, I think the priority for taking steps to expand

health insurance is that much greater today because our cross-subsidy mechanisms are breaking down.

Mr. LEE. Congressman Ryan, I think the first step-back point is the tax benefit relative to uncompensated care distracts a little bit from the fact that most hospitals, for-profit and nonprofit, are compensated for that care from commercial private payers. This is one of the dysfunctions of our payment system. We have a vicious cycle caused by uninsured and underinsured costs in hospitals being picked up by employers, by those that have insurance, driving those prices up, driving to more uninsurance.

Mr. RYAN. So, let me ask you this: you are saying that it is the private dollars from the purchasers of health care that are paying for those uninsured, not the tax expenditures that are flowing through?

Mr. LEE. I am saying it is both, and I don't know the quantity of which is bigger, but it is absolutely a huge portion, which is hard dollars being paid by insured Americans, which is picking up a substantial portion of the uncompensated care costs in hospitals. Although the question that much of this hearing is focusing on is the tax status, the issue underlying driving hospital costs is part of a vicious cycle that is discouraging small employers from stepping up to the plate and getting insurance because it costs more. So, that is an important observation, I believe. The other is in terms of it isn't either-or——

Chairman HOUGHTON. Will you please be quick on this? Because we have got another panel.

Mr. LEE. That is my main observation on that question.

Chairman HOUGHTON. Fine. Thanks very much. Mr. Stark?

Ms. DAVIS. I think the answer is hands down it would be better if we would work on the problem of the uninsured. I mean, it is just a massive problem. It affects every——

Chairman HOUGHTON. I thought I had cut this off.

Ms. DAVIS. I would like to say, even if we——

Chairman HOUGHTON. Could we come back to you? Thank you very much. Go ahead, Mr. Stark.

Mr. STARK. I just had a comment for Mr. Lee on the idea of not-for-profits banding together to set prices. I believe that we certainly saw that in California. That was a reaction to the original move by Aetna and others to gouge big discounts out of separate units. So, this was the not-for-profits pushing back after they had been told that they would lose a lot of their patient base if they did not subscribe to discounts which were arguably too deep. So, it is kind of a bounce back and forth as the pendulum swings. Ms. Davis, of the 30 best in your study, how many were for-profit hospitals?

Ms. DAVIS. Those were nearly all nonprofits, but as Dr. Ginsburg said, most hospitals are nonprofit and all of the top four studies were nonprofit.

Mr. STARK. They are, and we did our own study to try and find in all of the for-profits, if any of them—this was just with U.S. News and World Report's study. The closest we can was one of two of them got a ninth ranking in orthopedic surgery, and that was about as close as any quality hospital got in the profit group. None of them are teaching hospitals, to my knowledge, and then, of course, we have the example set by HCA, HealthSouth, and Ten-

ant, who are the largest criminals, Tenant in California recently having killed 167 people by unnecessary heart procedures. I don't think you can make a very good case for the for-profit community based on the record that they have established in this country to date. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you very much. Mr. Johnson?

Mr. JOHNSON. Thank you, Mr. Chairman. You know, since enactment of the Medicare bill last year, many employers have expressed interest in offering high-deductible insurance plans along with HSAs to their employees. You know, employees will be paying out of their pocket for their hospitals expenses. How important is transparency to them? Can you tell me if there is any transparency between doctors' costs, too?

Ms. HERZLINGER. Health Allies was started for just that purpose. It was started with the idea that there would be high-deductible accounts with Health Risk Assessments (HRAs) that the employer, employee, or somebody else funded, for which they could use the resources to pay part of that deductible. Health Allies, which is what I referred to in my testimony, does is it makes transparent to the user what the prices are for different procedures and for different physicians. It also negotiates a discount on their behalf. So, by aggregating individuals, it makes these individuals as powerful as a group in seeking discounts.

Mr. JOHNSON. Yes, sir?

Mr. LEE. Congressman Johnson, we have a problem with the lack of transparency of hospitals. It is a real crisis at the physician level, and generally there is not good information there. There are a few very small, baby steps. The National Committee for Quality Assurance has physician recognition programs for physicians that provide diabetic care or cardiac care, that provides a bundle of measures to say this doctor is really good for these areas of care. Among the issues we happen to be working on with CMS is to get to the physician level of measurement and choice so consumers can get that information of who should do my knee surgery. We are not there today.

Mr. JOHNSON. Yes, sir?

Mr. GINSBURG. I think a limitation of HSAs, according to the way the legislation is written, is defining HSAs in terms of a deductible and if you talk about someone who is being hospitalized, inevitably they exceed that deductible. So, the only price incentives they face, other than whether to go into the hospital or not, is just if they have coinsurance where they will bear, say, 20 percent of the price differences across hospitals or if they have co-payments.

I think that there is some potential, which perhaps future revisions of HSAs could address, about some incentives to choose better providers or, in a sense, to make choices which do not involve a large deductible and which would not qualify. We published something in December reflecting a conference on what are the innovative ideas in patient cost sharing. I am concerned that many of those ideas just would not fit under the way that the Congress has defined HSAs, and it is an area that you might look at.

Mr. JOHNSON. I alluded to the fact that not-for-profits were building more buildings, more hospitals—they are in our area, for sure, and you all nodded yes—over the for-profits. Are those beds

going to be usable? Hospitals where I am are turning those bed into family rooms, for crying out loud, because they cannot fill them. Do you think that the construction of not-for-profit hospitals is too high? If they were taxed, they wouldn't be building them, would they? Does somebody want to respond?

Mr. LEE. I would just respond, Congressman Johnson, that health care very much is local, and in some communities there is undercapacity because of lack of building, but in many communities, there is overcapacity. So, I think that needs to be looked at on a community-by-community basis in terms of the need for new hospitals beds or not.

Mr. JOHNSON. Yes, but are not-for-profits building more than for-profits? Because it used to be the other way around, it seems to me.

Ms. KANE. It really is a function of your local market. That is who is there, perhaps you know, that is where they tend to stay. For-profits can really cruise the country and look for a location they want to locate. Nonprofits tend to stay local and look for local opportunities, so they may be more likely to build in your market because that is where they are.

Mr. JOHNSON. Thank you. I appreciate your comments.

Chairman HOUGHTON. Thanks. Mr. Sandlin?

Mr. SANDLIN. Thank you, Mr. Chairman. I just have one question. Dr. Ginsburg, from the information that has been provided to me, most of these tax-exempt hospitals are currently running at about a 5-percent margin, and if we change the tax-exempt status of those hospitals, do you think we run the risk of those hospitals closing or going bankrupt, and then obviously not being able to provide services to the communities?

Mr. GINSBURG. Yes, well, nonprofit hospitals need to earn a margin if they are to have capital to expand and replace themselves. So, because they cannot get equity capital, they have to rely on their retained earnings and debt. So, just seeing a nonprofit hospital earn a return is not a sign that it is going awry. Certainly, anything which took away the tax-exempt status would certainly hurt the abilities of these hospitals to either continue operating or certainly to have capital investment to expand.

Mr. SANDLIN. If, in fact, it is only 5 percent, not only would it take away, but it might drive the stake in the heart to kill the hospital by taking away the tax-exempt status. Is that correct?

Mr. GINSBURG. I do not have information to be able to agree or disagree about how important that would be.

Mr. SANDLIN. Would you think that taking away the tax-exempt status is a larger financial penalty than the 5-percent margin under which they are currently operating?

Mr. GINSBURG. That is really a quantitative question as to how valuable that tax——

Mr. SANDLIN. Would you rather have a 5-percent margin or the tax-exempt status?

Mr. GINSBURG. I am not prepared to speak to that.

Mr. SANDLIN. You do not know if you would rather have a tax-exempt status or a 5-percent margin?

Mr. GINSBURG. No, I do not know and they have both now.

Mr. SANDLIN. Well, I think that answers the question. Thank you.

Chairman HOUGHTON. Well, thank you very much. This is the beginning of a long process. I appreciate your expertise and your frank discussion. Good luck and we will be in touch with you later. Thanks very much. I would like to ask the second panel to come up here. That is David Bernd, who is Chair of the American Hospital Association (AHA) Board of Trustees; Randy Sucher, Executive Vice President and Chief Operating Officer (COO) of Southern Medical health System, in Mobile, Alabama; Richard Morrison, Regional Vice President, Florida Hospital for government; and also Harold Cohen, Dr. Cohen, a consultant with Hal Cohen of Baltimore. I am sorry that Ben Cardin is not here, Doctor, wherever you are, because he wanted to introduce you, but I am sure he will have something to say when he comes back. He is managing a couple of bills on the floor.

All right. We are going to try to do this a little more expeditiously because we do have votes coming up in about an hour. If we could have your testimony, and I think the panel has thinned out a little bit so we will not have quite as many questions. I really appreciate your being here, and, Mr. Bernd, will you begin?

STATEMENT OF DAVID BERND, CHAIR, AMERICAN HOSPITAL ASSOCIATION BOARD OF TRUSTEES

Mr. BERND. Thank you, Mr. Chairman. My name is David Bernd. I am president and CEO of Sentara Healthcare in Norfolk, Virginia, and chairman of the board of Trustees of the AHA. Sentara began in 1888 as a 25-bed retreat for the sick and now serves more than 2 million people in the Hampton Roads area. That is a big change, but what has not changed is the caring and compassion with which our people do their jobs. All the good things that hospitals do are done in the face of mounting challenges; 44 million uninsured Americans is one of them. It is a fundamental problem that permeates every aspect of our health care delivery system. We recognize that hospital billing and collection policies have come under increased scrutiny. Hospitals, led by the AHA, are taking substantial steps to demonstrate that their compassion extends from the bedside to the billing office.

The AHA board recently developed a set of principles and guidelines to help hospital leaders as they struggle to help patients of limited means. My written testimony has details, but the guidelines cover topics such as offering discounts to patients who do not quality for charity care and making sure patient accounts are pursued fairly and consistently. As of today, over 2,500 hospitals have signed a confirmation of their commitment to follow these guidelines, and the number is rising.

With recent guidance that we requested from the Federal government, it is now clear that fear of violating Federal regulations no longer should impede hospitals' charity care efforts. At the same time, we know that the transparency factor is also important. We are attacking this issue on two fronts: we are working with CMS, the Joint Commission, and other organizations on the quality initiative to make information about hospital quality available in a useful way to the public. Nearly all hospitals eligible to take part

in the initiative are doing so. A consumer-oriented website will be up early next year.

The important goal of transparency is pricing information. Our principles and guidelines include this statement: hospitals should make available for review by the public specific information in a meaningful format about what they charge for services. The key word, Mr. Chairman, is "meaningful." Publishing our list of master charges would require patients to sift through a document containing tens of thousands of diagnostic codes. There are better, more meaningful ways to do this, and I will outline some of these suggestions in my statement.

Regardless of how prices are displayed, hospitals have always helped patients who cannot pay. At Sentara, for instance, 63-year-old Cora Brown came to us without insurance and was diagnosed with colon cancer. Our staff treated her with the respect and compassion every human being deserves, helped her apply for Medicaid, and covered most of her medical expenses that were not covered. Cora is just one example of a patient who received care regardless of her ability to pay, and we are just one example of how so many hospitals extend their compassion to the financial side of caring.

Some have claimed that hospitals are subsidized for this kind of care through special payments from Medicare. This is inaccurate. While every hospital in every community serves patients who are unable to pay, Medicare's disproportionate share payments and indirect medical education payments, while important to the industry, do not go to every hospital. They are targeted only to specific hospitals, and they are not intended by Congress to offset or subsidize the actual costs of uncompensated care that individual hospitals incur.

Finally, let me touch on the tax-exempt status, Mr. Chairman. Hospitals are the lifeline of many communities, and not-for-profit hospitals, which receive certain tax exemptions, are governed by the community and exist to meet the community's needs. Since 1969, the promotion of health has been explicitly recognized as a purpose meriting tax exemption. In 2002, 84 percent of community hospitals reported that they work with other providers or public agencies to conduct community health assessments. They determine what services are needed, and then they work together to make those services happen. From homeless shelters to school vaccination programs to free health screenings, hospitals take medical care far beyond the hospital walls to get at where it is needed—in the community.

To close, let me again stress that the people of America's hospitals work hard every day to meet the needs of their communities. They are why our Nation has the best health care in the world. Making sure all Americans can take advantage of that health care is a huge challenge. Hospitals are working diligently to address the specific issues that I have outlined here today, and nothing will make a greater improvement than all of us working together to address the real need: health insurance coverage for everyone. I will be happy to respond to your questions. Thank you.

[The prepared statement of Mr. Bernd follows:]

Statement of David Bernd, Chair, American Hospital Association Board of Trustees

Good morning, Mr. Chairman. I'm David Bernd, president and chief executive officer of Sentara Healthcare in Norfolk, Virginia. I also serve as chairman of the American Hospital Association's Board of Trustees. On behalf of our almost 5,000 hospital, health care system, network and other health care provider members, the AHA appreciates the opportunity to testify today on "Tax Exemption: Pricing Practices of Hospitals."

Sentara Healthcare began in 1888 as a 25-bed Retreat for the Sick. Today it is the largest not-for-profit, integrated health care provider in southeastern Virginia and northeastern North Carolina, serving more than 2 million people. Our facilities include six acute care hospitals, one extended stay hospital and more than 70 other sites of care, 25 primary care practices and a full range of health coverage plans, home health and hospice services, physical therapy and rehabilitation services, urgent care facilities, ground medical transport services, mobile diagnostic vans, and two health and fitness facilities. We are also the region's only Level One Trauma Center.

The Effect of the Health Insurance Crisis on Patients and Hospitals

Mr. Chairman, our nation's health care system is in desperate need of repair. Medicare and Medicaid, two government programs that support half of the care hospitals provide, reimburse hospitals at less than the cost of providing those services. Insurers negotiate big discounts. Meanwhile, rapidly rising technology costs, aging facilities in need of repair, and a shortage of workers all place increasing burdens on hospita l resources that are already struggling to meet rising demand. T hese factors combined make it difficult for the people of America's hospitals to continue meeting the growing health care needs of their communities.

But more important are the nearly 44 million Americans whom the Census Bureau estimates have no health insurance coverage—although as many as 82 million, according to a recent report, lack health insurance coverage at some point during the year. Millions more are underinsured. Mr. Chairman, we lack a social policy in America that provides health care coverage for all. In the meantime, hospitals are asked to fill the gap, and they try to, for everyone who walks through their doors. In fact, in 2002, hospitals absorbed more than $22 billion in uncompensated care costs for patients who couldn't pay for the care they needed. But more is required to meet the health care needs of the uninsured, and America's hospitals cannot solve the problem on their own. To do so would jeopardize their ability to survive and serve the health care needs of everyone in their community, especially with one-third of hospitals losing money overall, and another third on the financial brink.

The AHA is a national partner in the Cover the Uninsured effort, sponsored by the Robert Wood Johnson Foundation to shine the national spotlight on the plight of the uninsured. Of the more than 2,300 local events held nationwide during Cover the Uninsured Week last month, hospitals sponsored or took part in many of the more than 1,000 health and enrollment fairs that included helping eligible residents sign up for coverage programs.

And many hospitals have staff on duty who are dedicated to helping patients of limited means identify and sign up for Medicaid or other programs, or to access charity care in other forms.

The AHA's Principles and Guidelines

Recognizing that the growing problem of the uninsured was demanding national leadership as hospitals struggled to help their patients who could not pay, the AHA convened a broad-based advisory group of hospital leaders to develop comprehensive principles and guidelines around better hospital billing and collections practices. These guidelines were discussed by hospital leaders across the country and approved by AHA's Board of Trustees. This effort to provide comprehensive guidance to the hospital field will make a positive contribution to helping many Americans better afford hospital care.

The principles and guidelines (attached), sent to all hospitals in December 2003, put patients first and embody the longstanding mission and goals of every hospital:

1. Treat all patients equitably, with dignity, with respect and with compassion.
2. Serve the emergency health care needs of everyone, regardless of a patient's ability to pay for care.
3. Assist patients who cannot pay for part or all of the care they receive.
4. Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care.

The document also includes specific guidelines on:

1. **Helping Patients with Payments for Hospital Care,** which includes making available to patients and others in the community meaningful information about the hospital's charges;
2. **Making Care More Affordable for Patients with Limited Means,** which includes offering discounts to patients who don't qualify for charity care; and
3. **Ensuring Fair Billing and Collection Practices,** which includes ensuring that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.

Some state hospital associations have developed similar guidelines to help uninsured and underinsured people. The Healthcare Association of New York State (HANYS), for example, issued guidelines in January 2004. HANYS firmly asserts the principle that "fear of a hospital bill should never get in the way of a New Yorker receiving essential health services." The guidelines help hospitals meet that commitment, including a sample document to guide hospitals in communicating consumer-friendly financial assistance policies to the public in language that the patient can understand.

HANYS surveyed its members to ascertain their status with implementing HANYS' financial aid/charity care guidelines, and to date has received responses from almost 70% of the hospitals. About 80% of respondents indicated they have updated their policy within the last six months. More than 75% have eligibility standards at or above 200% of the federal poverty level. And more than 95% initiated staff training programs on charity care policy.

Clearly, the hospital field is responding to the problems at hand and to the AHA and state hospital association guidelines. In May, we asked hospitals to share, in writing, their commitment to fulfilling the AHA's principles and guidelines. Just weeks later, more than 2,300 hospitals have signed an AHA Confirmation of Commitment, pledging that they either meet or exceed these guidelines or are working diligently to do so.

The AHA guidelines have also met with support from consumer groups. Families USA, a leading consumer health care advocacy organization, said "our organization believes the Principles and Guidelines adopted by the AHA Board of Trustees—are an important and commendable initiative." The Access Project, committed to improving access to care for uninsured and underinsured people, wrote, "We applaud the American Hospital Association's Principles and Guidelines—We believe that American hospitals and patients would benefit from their full implementation." And the National Alliance for Hispanic Health commended the guidelines, calling them a critical step toward better serving the uninsured.

Sentara Healthcare is a strong supporter of these guidelines, and as AHA Chairman I was proud to be the first to sign the Confirmation of Commitment. But we are certainly in very good company.

Cooley DickinsonHospital, a 125-bed community hospital in Northampton, Massachusetts, is just one example of a hospital that exceeds the guidelines. Working with Hampshire HealthConnect, a community grassroots organization dedicated to helping uninsured people, Cooley Dickinson has established a program to reach out to uninsured patients who need help with their medical bills. At registration, patients are provided a one-page flyer describing how they can get assistance. Hampshire HealthConnect staff, which initiates contact with patients during their stay in the hospital, provides a full range of services to help patients qualify for coverage under a variety of programs. In 2003 the program assisted 1,428 uninsured and underinsured patients, connected 879 patients to free or reduced cost medication programs, helped 479 patients gain approval for "Free Care" to cover their hospital bills, and provided 125 patients with access to mental health counseling.

The Challenge of Federal Regulations

In working to fashion the AHA's principles and guidelines it became clear that hospitals were concerned about violating federal regulations governing billing and collections that had accumulated over many years. This became an impediment to hospitals' efforts to assist patients of limited means with their hospitals bills. The rules are numerous, often confusing and, as even the administration acknowledged, "scattered" among many different official publications.

The AHA sought to address that issue and asked the administration to bring new clarity to the rules to assist hospitals in their efforts to improve their charity care and other payment policies for patients of limited means. We produced an analysis of the rules and asked the administration for help in clearing away the unneeded regulatory confusion.

Thanks to Secretary Thompson's leadership, the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) released guidance addressing many of the concerns AHA raised on behalf of the field. The agencies re-

cently followed up on that guidance at a forum that gave hospitals an opportunity to ask specific questions. Because of these efforts, hospitals are moving ahead to improve their charity care and financial assistance policies and practices and make them available to even more patients of limited means.

Empowering Patients With Useful Information

Mr. Chairman, hospitals are committed to increasing the transparency of our efforts to best serve our patients. We agree that the current health care "system" does not serve Americans well in many ways, and that there must be more information available to consumers so they can make better decisions about their care. We're committed to working with the committee and others to develop these methods. One way we're already doing this is on the issue of quality.

For the last two years, we've worked with the Association of American Medical Colleges, the Federation of American Hospitals, CMS, the Agency for Healthcare Research and Quality, the Joint Commission, the National Quality Forum, AARP, AFL–CIO, the Disclosure Project, the American Medical Association and National Association of Children's Hospitals and Related Institutions on the public-private project, The Quality Initiative. The Quality Initiative has one goal: to provide patients and families with information to help them make decisions about care choices. It has already begun to collect and display hospital performance information about 10 measures of pneumonia, heart attack and heart failure care, and will soon expand to include more measures of heart attack, heart failure and pneumonia, and will add measures on the prevention of surgical site infections. Currently, the data are being displayed on CMS.HHS.gov in a manner that is designed for use by health care professionals. A more consumer-friendly display will appear on Medicare.gov early next year.

The Medicare Modernization Act of 2003 required that hospitals paid under the inpatient perspective payment system (PPS) report on these same measures in order to receive the full Medicare inpatient PPS inflation update for fiscal years 2005–2007. Even before this requirement was enacted, more than two-thirds of PPS hospitals had committed to participate in this project and to provide the public with useful information on hospital quality. Today, virtually all of the eligible hospitals are participating.

We're working to ensure transparency on other fronts as well. The government believes hospital pricing information should be transparent and so do we. We encourage all hospitals to communicate pricing information effectively with their patients. Our principles and guidelines include this statement:

"Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services."

The key word here, Mr. Chairman, is "meaningful." Publishing our master list of charges would mean patients would have to sift through a document containing tens of thousands of diagnostic codes, know all of the care that might be required for a specific condition and then piece together the information to arrive at a price.

While it is difficult for physicians and health care professionals—let alone a nonmedical person who suddenly is dealing with a medical crisis or condition—to predict the specific course of care and the associated charges, we agree that it is important for patients and families to have access to meaningful information on what their bill might be. Fear of a hospital bill should not deter a person from seeking medical care. Such information will help patients better understand their financial obligations and plan, with the hospital, for any financial assistance they may need.

There are many ways hospitals can share meaningful charge information with patients. One approach is to make available the average charges for the top 20 diagnostic related groups and top 20 outpatient procedures performed by the hospital, or itemize the charges by category of service, i.e., room and board, operating room, laboratory, etc. Providing patients with a range of charges for a particular condition also can help them understand how the actual services provided and associated charges may vary.

Another approach provides information for a hospital's average, low and high charge, broken out by severity for each of the 20 top conditions and 20 top outpatient procedures. This type of detailed charge information will provide a more definitive perspective on the range of charges for the most common services in the hospital.

The AHA's principles and guidelines also state that:

"Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance."

At Sentara, we routinely assist patients who may not have the ability to pay for medical care, like 63-year old Cora Brown. She came to our hospital without insurance and was diagnosed with severe anemia. Subsequent medical tests revealed

colon cancer that required surgery and chemotherapy. Later tests revealed liver cancer, and required yet more surgery and treatment. Sentara staff treated Ms. Brown with the utmost respect and compassion—as they would any patient—even while her medical bills continued to grow, and helped her apply for Medicaid. Sentara has covered most of Ms. Brown's medical expenses.

We helped Kathy Sievert, a Virginia Beach accountant who declined COBRA coverage after she was laid off following a company takeover. Ms. Sievert's rationale was that she was healthy and wasn't in need of medical care. That changed, however, on the day she was hit by a truck, and woke up at Sentara Virginia Beach Hospital with her bones surgically repaired and a $12,000 piece of titanium implanted in her leg. One of our patient advocates attempted to help her apply for State and Local Hospitalization assistance, but no funds were available. In the end, Sentara covered almost $45,000 of Ms. Sievert's medical care. And today, she has a new job with health insurance.

Government Special Payments to Hospitals

Some have claimed that special payments made through Medicare PPS and through the Medicaid program and other government programs are taxpayer-provided "subsidies" for the uncompensated care provided by hospitals—care for which no payment is received. While hospitals in every community serve patients who are unable to pay for their care, not all hospitals receive these special payments; they are targeted only to specific hospitals or other providers. A recent study prepared for the Kaiser Commission on Medicaid and the Uninsured showed that, in 2004, the Medicare program, the federal portion of the Medicaid program and several other government programs together provided $23.5 billion in additional payments to care providers. However, these payments are not intended to offset or subsidize the actual costs of uncompensated care that hospitals incur.

Medicare Disproportionate Share (DSH) Payments

Medicare disproportionate share payments are made to some, but not all, hospitals that serve low-income patients. While all hospitals provide uncompensated care, about 2,724 hospitals, or 55 percent, receive DSH payments. In 2004, according to the Kaiser Commission report, hospitals received $7.6 billion in DSH special payments. There is a minimum threshold that a hospital must meet to receive this special payment and a formula that calculates the amount a hospital receives. The formula combines two measures: the percentage of inpatient hospital days attributable to Medicare patients in the Federal Supplemental Security Income (SSI) program, and the percentage of inpatient days attributable to Medicaid patients. There is currently no measure for uncompensated care in the DSH payment formula.

In the Balanced Budget Refinement Act of 1999 (P.L. 106–113), Congress directed the HHS Secretary to collect data from hospitals on costs incurred in both the inpatient and outpatient settings for which the hospitals are not compensated, including non-Medicare bad debt and charity care. This is the first year that hospitals' data will be available for analysis.

Medicare Indirect Medical Education (IME) Payments

The Medicare program makes special payments to teaching hospitals under the inpatient PPS. A portion of these payments, directed to the 1,112 hospitals (23 percent of all hospitals) that train our future physicians, was $2.9 billion in 2004, according to the Kaiser Commission report. Indirect medical education payments compensate teaching hospitals for the costs they incur in training physicians. As a result of their education and research missions, teaching hospitals must offer expensive, specialized, and sophisticated services that may not be utilized optimally. Often, teaching hospitals care for the most medically complex and costly patients in our health care system. The Medicare inpatient payment system does not adequately measure and compensate teaching hospitals for these additional patient care costs. The IME payment adjustment is designed to account for patients' severity of illness and the inefficiencies in operating a hospital where teaching and research occur. For example, physicians-in-training may order extra lab or other diagnostic tests because they are inexperienced in practicing medicine. They may also ask questions and rely on other health care personnel in the hospital for help, thus making professional staff less efficient in delivering patient care. IME payments are calculated using a formula that is based on an individual hospital's resident-to-bed ratio. It does not include a measure of uncompensated care.

Today, even including the targeted payments mentioned above, Medicare pays only 98 cents for every dollar of care provided by hospitals to Medicare beneficiaries. If Medicare DSH and IME funds were to somehow be redirected to cover hospitals' uncompensated care costs, rather than their current purpose of helping hospitals

provide care to Medicare beneficiaries, the Medicare reimbursement would drop to an estimated 91 cents for every dollar of care provided by hospitals.

Tax Exempt Status—Key to Community Care

The underpinning for charitable tax exemption is public support for activities that serve the larger good—a concept that encompasses the broadest range of public purposes. The governing body of a charitable organization is based in the local community, and has a fiduciary duty to see that the organization is organized and operated to fulfill its charitable mission.

Since 1969, the promotion of health has explicitly been recognized as a purpose meriting tax exemption. Health care organizations may be awarded tax-exempt status by demonstrating that they promote health in a manner that benefits the community as a whole. The premise underlying the community benefit standard is that the promotion of health in a manner that benefits the larger community serves a public purpose. The promotion of health alone is not sufficient, however; how it is done, when, and for whom are important factors. Tax exemption requires more. The focus is not on what the hospital does but whether those actions respond to community need. Providing charity care has been only one way to demonstrate that benefit.

The community benefit test is still a sound and viable basis for awarding tax-exempt status to hospitals. It places the focus at the local level and examines the merits of individual situations against the community environment in which they serve. The issue has been and should continue to be whether they are providing public benefit. Exemption is given in return for responding to the community's needs.

Hospitals are open 24 hours a day, seven days a week. The women and men who work there—on the day shift, the swing shift or the night shift—provide compassionate care and help bring new life into the community. They provide medical care both within our four walls and in other settings.

Hospitals provide emergency department care to all, regardless of their ability to pay. Hospitals' uncompensated care, as well as Medicare and Medicaid payment shortfalls, are costs absorbed in an effort to serve our communities.

But hospitals across the country also provide a wide-range of services for the benefit of those who don't seek care from the emergency department, the pediatric unit or any other hospital department. Instead they take the care to those who need it, delivering charity care and offering special non-compensated services and programs, including community education and outreach programs, health screenings, and subsidized medical education and research. The Cover the Uninsured Week activities I mentioned earlier are a good example of these efforts.

Most hospitals work with local providers and organizations to assess community status and needs. In 2002, 84 percent of hospitals reported that they worked with other providers or public agencies to conduct health status assessments of their communities. These assessments help them determine what programs and services should be targeted at various populations, such as minority, elderly or low-income, as well as to the broader populations.

In South Bend, Indiana, St. Joseph RegionalMedical Center works with more than 45 community agencies and businesses to provide health-related services to the working poor and underserved—those who do not have insurance and are not eligible for governmental assistance. Their program includes 65 volunteer physicians and almost 100 community and student volunteers providing a range of special services such as eye care, on-site mental health care, access to a food pantry, and assistance with food stamp applications. And St. Joseph's takes care of physician visits, lab work, medications, and inpatient and outpatient medical care.

Trinity Regional Medical Center in Fort Dodge, Iowa, created the CAN, the Community Action Network. Working with schools, government, law enforcement, local businesses and human services, CAN provides community health and wellness screenings, free health screening, and substance abuse and positive parenting programs.

These are just two specific examples of what hospitals around the country are doing to ensure the health of their communities. Others partner with community members to operate homeless shelters. They take medical care where it is needed, collaborate with others in their community to determine what non-medical services might be needed, and then work to provide it—all in an effort to do what it takes to improve the health of their communities.

Conclusion

Mr. Chairman, the people of America's hospitals work very hard, every day, to get high-quality care to all who come through their doors. They do it with caring and compassion that extend from the bedside to the billing office. And they do it in the face of mounting challenges. They are a key reason why our nation has the best

health care in the world. But ensuring that all Americans can take advantage of that health care when they need it is a huge challenge. We can take a giant step forward by working together to address the problem of the uninsured. We look forward to working with you to help solve that problem, and helping all Americans get the health care they need, when they need it.

Chairman HOUGHTON. Thanks very much, Mr. Bernd. Mr. Sucher?

STATEMENT OF RANDY SUCHER, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, SOUTHERN MEDICAL HEALTH SYSTEMS, INC., MOBILE, ALABAMA

Mr. SUCHER. Thank you, Mr. Chairman. I come from Southern Medical Health Systems, a small for-profit company in Mobile, Alabama. We operate Springhill Medical Center, a private for-profit hospital. Establishing prices for hospital procedures has changed a lot, as we have talked today, as the practices of insurers and Medicare have evolved.

When Medicare adopted DRGs (diagnosis-related groups) in the eighties as the basis for payment, this generally introduced the concept of incentives for hospitals to control costs. At the same time, it reduced the impact of the line-item as that became less important because individual prices have a minimal effect on payments to hospitals except in the rare cases that an insurance company, HMO, or PPO paid for services based on a negotiated percentage of charges.

So, why do hospitals charge for every item and service? One, we still have to Medicare cost reports in order to properly allocate our costs. For those Medicare cost reports, we have to know the detailed charges to prepare those cost reports. We also identify the usage of items internally for internal control and internal costing purposes for hospital. We also provide those detailed items, in providing detailed bills with proper coding for insurance companies, as often requested by insurance companies or individuals. So, even though we do not like to, the practice of charging for every individual item still continues in health care today.

Charges are generally developed based on detailed analyses of prominent payer fee schedules in the current market. For example, if Blue Cross were to pay us $2,400 for an outpatient cardiac catheterization and the standard discount for Blue Cross patients in Alabama is around 50 percent, the standard charge may be 200 percent of that fee schedule amount. Determining the allocation of that overall intended charge to the components of care is difficult because every case is so different. As we have already talked today, health care is not like an assembly line in an automobile manufacturing plant. Every patient is very different, with varying complications, comorbidities, and severity of illness. Every physician is also different in their treatment protocols for each patient, using various supplies, pharmaceuticals, and diagnostic tests. Hospital care is really much more akin to a chef making seafood gumbo where almost all the outcomes are successful, but no two taste or cost exactly the same, and there are very large variations. In fact, hospitals have little control over the costs since only physicians and

not hospitals order the tests and ultimately determine the cost and what is done for each and every patient.

So, why do hospital charges vary so much from costs? One reason is that every payer contract we have includes a provision that for any particular individual patient, the payer will pay the hospital the lesser of the negotiated rate or the hospital's customary charges. Negotiated rates for each payer are generally a fixed rate that the insurer pays for an average episode of care across a broad spectrum of patients. For those patients that require a lot of extra care, like a heart cath patient requires a lot of stents, hospitals take a terrible beating when they take that average payment. So, hospitals cannot afford to not make money on the low-end cases by ever having their charges be less than the negotiated rates. High charge markups generally help hospitals avoid that catch-22.

The second reason for high hospital charges, as we already talked about a lot today, is cost shifting. It has occurred for many years in the industry and will continue to occur until massive changes occur. To make up for those payers that often pay hospitals below our actual cost—Medicare and HMOs included—and to be able to provide some level of free care, hospitals must shift unfunded cost to payers—generally PPOs, commercial insurance, and the uninsured—that pay some percentage of charges. In our case, these payers represent less than 10 percent of our revenue, but they comprise most or all of our profits.

The aforementioned item in the requirements that hospitals charge all patients the same price for the same services results in high prices for the uninsured. Until recent proposed changes in regulations, hospitals have been very concerned with giving discounts to patients other than as the result of contractual requirements. Now most hospitals, including ours, have a financial screening preregistration process whereby an uninsured patient can receive a discount based on ability and willingness to pay.

One thing we have talked a little about is efficiency. A lot has been said about rewarding hospitals for efficiency. One of the most perplexing aspects of Medicare, which espouses to reward efficiency through the DRG system, is that the application of the wage index guidelines actually penalizes hospitals like those in Alabama for providing a lower cost of care. We actually get much lower payment than most other hospitals in the Nation, even though we are, in fact, a low-cost provider State. Thank you very much.

[The prepared statement of Mr. Sucher follows:]

Statement of Randy Sucher, Executive Vice President and COO of Southern Medical Health System, Inc., Mobile, Alabama

Establishing prices for hospital procedures has changed as the practices of insurors and Medicare have evolved. Before Medicare converted to payment to hospitals based on DRG's (diagnosis related groups) in the 1980's, charges for individual items involved in providing care were calculated as a markup of estimated or actual costs. Individual item costs didn't matter too much because Medicare (and other payors) paid their pro-rata percentage of a hospital's total costs based on a ratio of costs to charges or average cost per day. This payment often included an add-on for uncompensated care at all hospitals and a return on equity for for-profit hospitals.

When Medicare adopted DRG's as the basis for payment, this introduced incentives for hospitals to control costs. Line-item pricing became even less important because individual item prices have a minimal effect on payments to hospitals, except in the rare cases that an insurance company, HMO or PPO paid for certain services

based on a negotiated percentage of charges. But in order to be able to allocate costs for Medicare cost reporting purposes, identify the usage of items involved in providing care to a patient for hospital internal costing purposes, and to provide a detail bill as often requested by insurance companies, the practice of charging for every individual item consumed by or for the patient has continued.

Charges are now developed based on detailed analyses of prominent payor fee schedules by procedure code. If Blue Cross pays $2400 for an outpatient cardiac catherization and the standard discount for Blue Cross is 50%, the charge (allocated to major components) may be 200% of the fee schedule amount. But the allocation of the intended overall charge to the components of the care is difficult because every case is so different. Health care is not like an assembly line at an auto manufacturing plant. Every patient is different with varying complications, co-morbidities and severity of illness. And every physician is different in their treatment protocols for each patient using various supplies, pharmaceuticals, and diagnostic tests. Hospital care is much more akin to great chefs making seafood gumbo, where almost all outcomes are successful, but no two taste or cost the same.

So, why do hospital charges vary so much from costs? One reason is that every payor contract includes a provision that for any particular patient, the payor will pay the hospital the lesser of the negotiated rate or the hospital's customary charges. Negotiated rates are generally a fixed rate that the insuror pays for an average episode of care (for example, a heart catheterization). Hospitals take huge losses on cases when complications occur, or when routine heart caths wind up involving expensive stents. So, Hospitals cannot afford to not make money on the low-end cases by having the charges be less than the negotiated rates. High charge markups generally help hospitals avoid this Catch 22.

The second reason for high hospital charges is cost shifting which has occurred for many years in the industry. To make up for those payors that often pay hospitals below our total cost (Medicare and HMO's included), hospitals must shift some of these cost to payors (generally PPO's) which sometimes pay a percentage of charges. Although these payors usually represent less than 10% of a hospital's revenue, they can comprise a fair share of hospital profits.

The requirements that hospitals charge all patients the same price for the same services results in high prices for the uninsured. Until recent proposed changes in regulations, hospitals have been very concerned with giving discounts to patients other than as the result of a contractual requirement. Now, most hospitals, including ours, have a financial screening process whereby an uninsured patient can receive a discount based on ability and willingness to pay.

As you know, hospital pricing policies are very complex and greatly misunderstood by the general public and many Medicare beneficiaries. Patients tend to focus on the detail bill, whereas hospitals and insurers look at the total bill for the services rendered. The industry is very interested in finding a solution to simplify and clarify our billing practices.

Mr. Chairman, thank you for the opportunity to testify before you today.

Chairman HOUGHTON. Thank you so much. Mr. Morrison?

STATEMENT OF RICHARD MORRISON, REGIONAL VICE PRESIDENT FOR GOVERNMENTAL AND REGULATORY AFFAIRS, ADVENTIST HEALTH SYSTEM, ORLANDO, FLORIDA

Mr. MORRISON. Mr. Chairman and Members of the Subcommittee, I am Richard Morrison. I am with the Adventist Health System based in Orlando, Florida. We started out in 1908 with one hospital. We now have 38 hospitals in 10 States. We believe we provide a significant amount of community benefit in the areas that we have our hospitals and nursing homes. I am not here today to talk specifically about that. I am appearing today to discuss the relationship between hospital charges and costs.

In my remarks, I would like to touch upon the relationship between cost and charges, charges and payment. Do charges differentially impact the uninsured? What does it cost to maintain a cur-

rent charge structure? Do charges serve a purpose? Can the current system be changed? Can transparency be improved?

There is, as has been noted, a very tenuous relationship between cost and charges in the health care industry. It should be noted, however, that this relationship did not come about overnight. It has taken place over a 30-year period and has been in response to changes in a Federal policy as it relates to Medicare and Medicare reimbursement, industry policy, and responses by the hospital industry in and of itself.

Hospitals do have charge masters, as, Mr. Chairman, you noted. Some may be as much as 25,000 items. This is the list from which the bills are created. The bills are not necessarily what gets paid. Everyone gets billed the same amount. What people pay or what the expectation of payment is is what differs greatly.

Medicare does not negotiate. It pays a flat amount based on a diagnosis. Medicaid pays a per diem. Health Maintenance Organizations (HMOs) and PPOs may pay on a Medicare-based DRG, they may pay a per diem, or in our case, they pay a discount off of charges. Almost all of our accounts with managed care companies are a discount off the charges, with a cap on the amount that we can increase our charges year to year.

The system of payment for the uninsured is a little more complex. For non-elective care and all admissions that come through the emergency room, we have the expectation of payment of zero for those with incomes under 150 percent of poverty or less, and that expectation of payment can rise to 60 percent of charges for those up to 400 percent of poverty, or about $75,000 for a household income of four people. Overall, these expected payments are subject to a cap of 25 percent of household income.

We also have methods available that can deal with those people who are above the 400 percent of poverty line so that they are not facing the full impact of high charges. We will work with these individuals and try to reduce their burden and can guarantee them a discount of 30 percent or more, depending upon their individual circumstances.

Charges do have some utility in health care even though there is only a passing relationship to cost. As was noted, they are still required by Medicare and some insurance companies and form the basis of payment. Maintaining the complex charge structure is expensive. We have to have over 300 people to track and audit the process of billing.

The charging structure also creates confusion for the consumer. This goes beyond the oft-quoted $10 aspirin. This includes the problem of giving a bill to an individual that says that the bill is $25,000, your insurance company paid $12,000, you pay $500. The question is: what happens to the rest? It gives rise to the issue of charges are too high in health care.

As we go to the high-deductible plans and the consideration of HSAs, hospitals must give consideration to extending discounts to the HSAs and the insurance companies themselves must begin to negotiate on behalf of the beneficiary so that discounts are passed on to the individual. Modifying our structure is going to be extremely complex. Even if we were to try to go to a diagnosis-based

group, we are still going to have to maintain the tracking of resource consumption.

If we look at the issue of transparency, I believe we do have transparency in outpatient services. Where it will become very, very difficult is looking at price transparency on the inpatient side because there is a tremendous amount of variation that can take place even for something so simply as a routine delivery. Cost can vary as much as 25 percent for something that you would expect to have a high degree of predictability. This is owing to the idiosyncratic factors of health of an individual as well as to practice patterns of a physician.

To conclude, hospital charges today are a product of market and regulatory behavior over the last 30 years. The connection of charges to cost is tenuous. Charges do have some utility and are still required to be maintained. Hospitals can deal with the imbalance of cost and charges through aggressive discounting, particularly to the uninsured. Changing the system to something more understood and administered will take extensive work and creativity. Mr. Chairman, Members of the Committee, thank you for the opportunity to speak with you today.

[The prepared statement of Mr. Morrison follows:]

Statement of Richard Morrison, Regional Vice President, Florida Hospital for Government, Regulatory and Public Affairs, Orlando, Florida

Mr. Chairman and Members of the Subcommittee:

My name is Richard Morrison; I am Regional Vice President for Governmental and Regulatory Affairs for the Adventist Health System in Orlando, Florida. We own and operate 38 hospitals in ten states. Since 1908 we have operated our flagship hospital, Florida Hospital, in Orlando. We established and operate our hospitals as part of our church mission to provide health and healing to our communities. From the beginning to the present day, Adventist Health System takes its obligation to meet the health needs of the communities in which we live seriously. In 2003, Florida Hospital provided uncompensated care to the uninsured/charity at a cost of $36 million dollars. In addition $29 million in cost of care was provided to those classified as bad debt. Finally, we provided $45 million in uncompensated cost of care to Medicare patients and $4 million in uncompensated costs to Medicaid patients. Beyond the direct cost of providing care, the hospital is committed to providing needed services to the community. In 2003, we spent $100million in expanding emergency care and other capital improvements. Over the next seven years we expect to spend over $700 million to expand capacity to meet the growing needs of our community.

I am appearing here today to discuss the relationship between hospital charges and costs. A great deal of controversy has recently been created over hospital charges. Many believe that hospital charges are too high and that they do not have any rational relationship to the cost of health care. The observation that health care costs and charges have, at best, an attenuated relationship is essentially correct. However, this relationship did not occur arbitrarily, nor did it occur overnight. Rather, the disconnect between costs and charges evolved over the span of nearly 30 years as a result of pressures exerted by the insurance industry, the federal government and from within the health care industry itself. It would take too long to recount the history of costs and charges. I have provided a short history on the subject for your review. In my remarks today I would like to touch upon six questions:

1. What is the relationship between cost and charges, and charges and payment?
2. Do charges differentially impact the uninsured?
3. What does it cost a hospital to maintain the current charge structure?
4. Do charges serve a purpose?
5. Can the current system be changed and what are the barriers to change?
6. Can transparency in pricing be improved?

As I noted there is a very tenuous relationship between cost and charges. The relationship varies hospital to hospital and within a hospital itself the mark up for items will vary dramatically. Frequently, less costly items receive a greater mark

up than more costly items. Furthermore, some charges for services, such as the cost for room and board and nursing care, understate the true cost. In short, in the hospital industry, as in every other industry, the practice of charging for individual items, is the chosen means, however imprecise, of allocating the cost and general overhead of the hospital and the overhead associated with a class of items.

Hospitals have extensive charge masters that may list as many as 25,000 or more line items. It is from this list that hospital bills are created. It is also the basis for information used in the quality assurance process, the utilization review process, cost accounting and for various reports to the state and federal government. All patients are charged on the same basis but all payers do not pay what is charged. Medicare pays based upon the diagnosis and sets the payment. Medicaid pays based upon a non-negotiated per day rate. Managed care companies pay upon a diagnosis basis, a per diem basis or a discount off of charges basis depending upon what is negotiated. I believe at this time almost all of the managed care (HMO and PPO) contracts at Florida Hospital are paid on a discount off charges basis. For our major contracts we also have a cap on the allowable increase in charges year to year. This cap is 5 to 6 percent. For those without health insurance the expectation of payment becomes a bit more complex. For non-elective care (and all admission through the emergency department) the expectation of payment can be $0 for those with incomes under 150% of poverty. The expectation rises to 60% of charges up to 400% of poverty or $75,400 for a family of four. Overall these expected payments are subject to a cap of 25% of household income.

For those who are above these income thresholds and who are uninsured, there is the real potential of having to face the full list price for hospital care. In 2003, only nine per cent of the uninsured at our hospital paid more than 75% of charges. This nine percent of the uninsured represented less than one percent of our patient population. Adventist Health Systems does work with all of these patients to reduce the financial burden and does have policies that allow the individual to receive a 30% discount regardless of financial status.

Charges still have some usefulness despite the fact that they vary significantly by institution and have only a passing relationship to cost. Charges are still required by Medicare and by some insurance companies. Medicare uses the reported charges to audit cost reports and as noted to calculate outliner payments. Insurance companies use the charges to project rates as well as to calculate payment in some cases. Internal to the hospital, charges give some measure of resource consumption but not one that is accurate at low units of analysis. At best charges give a relative comparison between services. They are not an elegant tool for management decisions. Maintaining the complex charge and reimbursement system is also expensive. Our organization has over 300 personnel whose primary responsibility is to track and audit the complex billing process. There are additional costs incurred as clinical personnel must record various charges for care taking away from actual clinical time.

Charges can also be extraordinarily confusing for the consumer. The problem goes beyond the oft-quoted $10 aspirin. It makes little sense to the patient to see a statement that says the hospital bill was $25,000, the insurance company paid $12,500, and the patient owes his co-pay of $500—yet we are required to provide information on this basis. A new challenge will occur for hospitals and consumers with the advent of high deductible health plans and health savings accounts if the current charge structure is not modified. To the extent high deductible plans become a significant factor in the market place, hospitals will have to consider the extension of discount policies to these plans. We must also insure that any discounts given to plans are extended to the beneficiary. In principle, there is not reason that health plans with significant presence in a market cannot negotiate discounts with hospitals on behalf of their members.

Modifying the current charging structure would be a complex task. A simple roll back of charges may work for some institutions that do not have discount based contracts and who do not have an extensive Medicare population. It would be more difficult to do this for those who have extensive contracts based upon discounts. In addition Medicare will need to adjust its method for determining outlier cases, as well as what it requires in its cost reporting methodology. Some have suggested that the hospital industry move toward a diagnosis based payment system. However, a diagnosis-based system will require some method of tracking resource consumption as well as a greater uniformity in physician practice patterns. The development of alternative methodologies will take time and resources. Remember it took thirty years to get us to where we are today

The final issue to consider is transparency. Is there a better way to provide consumers with a clearer sense of what they will pay for care? For most outpatient services this is not a major problem. Tests are fairly discrete and outpatient surgery

has more predictability. Inpatient care is far less predictable. Within a given institution the cost for treating a specific diagnosis can vary greatly. Even something as seeming routine as a normal delivery can vary in cost by as much as 25%. This variance can be attributed to differences in physician practice patterns as well as the health condition of the individual. Further, a given diagnosis group may be made up of several different individual classification of disease codes. At the hospital level, there are generally not enough cases in a particular diagnostic category to provide a meaningful average.

To conclude, hospital charges today are a product of market and regulatory behavior over the last thirty plus years. The connection of charges to cost is tenuous. Charges do have some utility and are still required to be maintained. Hospitals deal with the imbalance of cost and charges through aggressive discounting particularly to the uninsured. Changing the system to something more easily understood and administered will take extensive work and creativity.

Mr. Chairman, members of the committee thank you for the opportunity to speak to you today.

Chairman HOUGHTON. Thanks, Mr. Morrison. Dr. Cohen—and again, I am sorry that Ben Cardin isn't here to introduce you.

STATEMENT OF HAROLD A. COHEN, PRESIDENT, HAL COHEN, INC., BALTIMORE, MARYLAND

Mr. COHEN. Thank you, Mr. Chairman, Members of the Subcommittee. I am here today to testify regarding the experience of Maryland's Health Services Cost Review Commission (HSCRC), which is the State agency in Maryland which regulates hospital rates, as well as to answer any questions you might have regarding the lessons to be learned regarding hospital charge levels in the rest of the country.

The commission was created by the Maryland legislature in 1971 and began setting rates in 1974 for all acute care hospitals. In 1977, Maryland entered into a demonstration with Medicare and Medicaid whereby both government agencies agreed to waive Federal supremacy and to pay Maryland hospitals on the basis of rates set by the Health Services Cost Review Commission, subject to a waiver test. That Medicare waiver was later changed to an operating waiver subject to a payment test with the considerable support of Senator Mikulski.

In setting rates, the commission's goal is to finance the mission of efficient and effective hospitals. Hospitals are expected to have missions that include care to the poor, and some hospitals' missions included teaching and research. The commission sets rates by comparing costs and making adjustments which are not all that dissimilar to the kinds that the Medicare system makes. I want to briefly discuss pricing levels, equity, and access, and, if there is time, talk about cost containment and data availability.

Since pricing levels are a focus of this hearing, I am going to focus on them and the statistics that I present in all the exhibits come from the AHA's 2004 edition of Hospital Statistics, which has 2002 data. The national average markup, as it shows, was almost 131 percent, meaning, on average, hospitals charge about $23,100 for an admission that costs $10,000.

There is a huge range in markups. Maryland has by far the lowest markup, and well below the next-lowest, largely because prices mean something. It is what, largely, everyone pays. In addition, there is a common method for setting rates in Maryland, along

with pooling of uncompensated care, so that the markups of all hospitals are fairly similar. In other States, there is much greater variation in markups, with many hospitals' markups being much higher than the national or State average, some having charges more than 10 times their costs.

For hospital services, the typical markup in Maryland is about 20 percent. That 20 percent roughly reflects about 8 percent for uncompensated care, because hospitals have to get paid for the costs of the care, that they provide to the patients who don't pay; about 7 percent for approved discounts; and about 5 percent turns out to be for profits. That Exhibit 2 shows the average charge per case for the Nation and each State. Again, Maryland has by far the lowest average charge, being $9,945, which is a little more than half the national average. New Jersey had the highest. The average charge per case was $18,100 in 2002; it is now over $20,000, which indicates that, as Paul Ginsburg mentioned in the first panel, that once a patient goes to the hospital, they are almost certainly going to exceed the deductible in a high-deductible policy.

I want to discuss briefly—well, I am just about out of time, so you can see the data. People in Maryland—one example of the low charges in Maryland is that Medicare beneficiaries in Maryland pay 20 percent of charges, and 20 percent of charges is about $70 million less than paying the national co-pays, which are based on 20 percent of national charges—though they are coming down. There is a huge savings to the beneficiary. Thank you very much.

[The prepared statement of Mr. Cohen follows:]

Statement of Harold A. Cohen, Ph.D., Consultant, Cohen, Inc., Baltimore, Maryland

Good morning Mr. Chairman and members of the Subcommittee. My name is Hal Cohen and I am President of Hal Cohen, Inc., a healthcare consulting firm in Baltimore, Maryland.

Before addressing the substantive issues, I would like to introduce myself to you. Healthcare consulting is my third career. I am an economist with a Ph.D. from Cornell University. My first career was teaching economics, primarily government and business courses at the University of Georgia, and doing research in health economics. My second career was as the Executive Director of the Health Services Cost Review Commission (HSCRC), the State agency that sets hospital rates in Maryland. I have been a full time consultant in health economics for the past 17 years, almost exclusively related to hospital financing and public policy issues. My clients have included almost all sectors of the industry, including the federal government, state governments, hospital associations, health systems, hospitals, insurers, HMOs, self-insured companies, self insured Taft-Hartley plans, purchasing coalitions, and other consulting firms.

Along the way I have served on three Federal Committees. I was an original appointee to the Prospective Payment Assessment Commission (ProPAC) and served as the Chair of its Committee on Hospital Productivity and Cost Effectiveness. I was a member of the National Committee on Rural Health and served as the Chair of its Finance Committee. I was also a member of the National Committee on Vital and Health Statistics. I was a Commissioner on the Maryland Health Care Access and Cost Commission, which established the Standard Benefit Plan for the small group market, produces hospital and HMO report cards, and maintains the state health expenditure accounts.

I am here today to testify regarding the experience of Maryland's HSCRC and answer any questions you might have regarding lessons to be learned regarding hospital charge levels in the rest of the country.

The HSCRC was created by the Maryland legislature in 1971 and, beginning in 1974, assumed authority to set the rates for all acute care hospitals in Maryland. In 1977, Maryland entered into a demonstration with both Medicare and Medicaid whereby both government agencies agreed to waive federal supremacy and to pay Maryland hospitals on the basis of the rates set by the HSCRC, subject to a waiver

test. That "Medicare waiver" was later changed to an operating waiver subject to a payment test with the considerable support of Senator Mikulski.

In setting rates, the Commission's goal is to finance the mission of efficient and effective hospitals. Hospitals are expected to have missions that include care to the poor and some hospitals' missions include teaching and research. The Commission sets rates by comparing hospital costs and making adjustments for hospital differences that are not significantly different in kind than the adjustments made under the Medicare system.

I want to briefly discuss four areas of results: pricing levels, equity, access, and cost containment. I briefly touch on data availability.

Pricing Levels

Because pricing levels are a focus of this hearing, I start with and emphasize this subject. Exhibit 1 shows the mark-up of charges over cost for the nation and for each state in 2002. All data used in the attached Exhibits are calculated from the American Hospital Association's annual publication, *Hospital Statistics*. The most recent data available are for 2002. The national average mark-up of almost 131% means that, on average, hospitals charge 131% more than cost, so the average charge for an admission costing $10,000 would be $23,100.

Note the range in mark-up for various states. Because all payers pay Maryland hospitals on the basis of charges, the mark-up is well below the national average and well below the state with the next lowest mark-up. In Nevada, the 213% mark-up means that the average charge for an admission costing $10,000 is $31,300. In Maryland, the average charge for such an admission would be $13,500. In addition, since there is a common method for setting rates in Maryland (and pooling of uncompensated care above the state average), the mark-ups of Maryland hospitals are very similar. In other states, there is much greater variation in mark-up among hospitals, with many hospitals' mark-ups being much higher than the national average, some having charges more than ten times cost.

The 35% mark-up reported by the AHA for Maryland in 2002 is much higher than the AHA has reported in previous years and is much higher than the mark-up for regulated hospital services of 20% (per the HSCRC's annual disclosure). (For example, physician services are not regulated.) Maryland's mark-up on regulated services reflects three factors: uncompensated care—about 8%; contractual allowances (primarily Commission approved discounts, but denials, too)—about 7%; and profits—about 5%. Maryland, like everywhere else, has high mark-ups (and high contractual allowances) associated with hospital billed unregulated physician services.

Exhibit 2 shows the average charge per case for the nation and for each state. Again, Maryland had the lowest average charge ($9,945), little more than half the national average. New Jersey hospitals had the highest average charge at $27,200, or 1.5 times the national average.

I want to discuss two aspects of charge levels in Maryland. As part of the original negotiations with Medicare and Medicaid, those payers both pay 94% of charges. In order to allow Medicare and Medicaid Managed Care Organizations (MCOs) to compete fairly with their fee-for-service counterpart, those MCOs also get the same 6% discount.

Thanks in large part to Congressman Cardin, Maryland hospitals were included when Medicare began to pay hospitals directly for the costs of Graduate Medical Education associated with Medicare HMO members. In order to assure that Maryland hospitals did not get paid twice, and to attain Congress' intention that Medicare HMOs not be discouraged from using teaching hospitals due to higher costs, the HSCRC gave Medicare MCOs an additional discount to reflect those direct payments.

One final example. Prior to Medicare's outpatient PPS, a Medicare beneficiary's co-insurance was 20% of hospital charges. In Maryland, that amounted to about 20% of Medicare's total obligation. For the nation as a whole, because of huge outpatient mark-ups and relatively low Medicare payments, 20% of charges amounted to 50% of Medicare obligations. When Medicare announced its outpatient PPS, it published the new national co-payment for each outpatient service in the *Federal Register*. Those co-payments were based upon 20% of national charges. I advised my client CareFirst Blue Cross Blue Shield, a major provider of Medigap insurance, that this proposed change would cost Medicare beneficiaries in Maryland approximately $80,000,000. CareFirst directed me to try to convince HCFA (now CMS) to allow Maryland's Medicare beneficiaries to continue to pay 20% of state controlled charges. Using Maryland's outpatient database, I showed HCFA officials that the impact of changing from 20% of Maryland charges to the new national co-pays based on 20% of national charges would increase the co-payments for Maryland beneficiaries by over 70%! HCFA determined that such an effect was contrary to Con-

gressional intent. HCFA agreed that the outpatient co-pay is part of the outpatient payment system and, thus, covered by the Medicare waiver. As a result, Maryland beneficiaries still pay 20% of charges as set by the HSCRC. As noted earlier, this more appropriate division of payment obligation saves Medicare beneficiaries and those responsible for paying their co-pays close to $80,000,000—though the savings are somewhat reduced by the national co-payments moving closer to 20% of the Medicare obligation.

Equity

In Maryland "charges" and "prices" have the same meaning for all payers. In other states "prices" paid are, typically, significantly lower than "charges". Since charges at each hospital are the same for the same services, and, in Maryland, all payers are responsible for paying charges, the uninsured face the same prices that everyone else does. Reasonable prices mean that co-insurance percentages associated with out-of-network care are equitable. Reasonable prices mean that when a covered person is taken to an out-of-network hospital in an emergency situation, the rates faced by the insurer, HMO, self-funded plan, etc., are equitable. In other states, significant inequities and market distortions arise whenever the payment obligation is based upon charges, as in the examples above.

Access

As noted earlier, approved rates include uncompensated care. (In order to reduce the advantage of shopping to avoid hospitals with high mark-ups for uncompensated care, any approved uncompensated care above 8% is financed via a pool financed through the rates of all hospitals.) All hospitals in Maryland share in the burden of care to the uninsured. There are no public hospitals; there were, but they have converted to private not-for-profit hospitals.

One of my most enjoyable days at the HSCRC was at a Sunset Hearing before the Maryland legislature around 1986. At that hearing, the Legal Aid Society testified that its sister agencies in neighboring states had many cases associated with patient dumping, but that they had never had a case in Maryland due to the equitable funding of uncompensated care at Maryland hospitals. The Society urged the Legislature to not sunset the HSCRC.

Cost Containment

The legislation made the financing of hospitals' missions dependant on Maryland hospitals being more efficient. In addition, as I mentioned, the Federal waiver comes with conditions regarding cost containment. Exhibit 3, also from AHA *Hospital Statistics,* shows the rates of increase in cost per adjusted admission since Maryland began regulating hospital rates. (An adjusted admission is a standard measure used to account for outpatient activity.) Exhibit 3 shows that, since Maryland began setting rates in 1974, it has had the lowest rate of increase in cost per adjusted admission than any other state (with Arizona being second). Most importantly, during that period, Maryland costs went from 23.6% above the national average to 5.7% below the national average. Exhibit 4 gives the primary method by which Maryland hospitals achieved this cost improvement. Since 1981 (I did not have the older data available), Maryland hospitals had the second highest reduction in average length-of-stay (ALOS), moving from an ALOS 11.7% above the national average to 11.2% below the national average. During this entire period, as now, Maryland's rate setting system provides complementary incentives for both hospitals and payers to manage the care of inpatients. Payers benefit from managing care because they pay on the basis of the itemized charges to their patients. Hospitals benefit because they face the same set of incentives as is provided by Medicare's PPS. I believe this coordination of incentives at the level of the individual patient adds to the, largely, provider bases incentives upon which Medicare's PPS relies.

Data

In Maryland, information regarding hospital rates, charges, ALOS, and volumes by service is public and amazingly current. There are readily accessible inpatient and outpatient databases regarding charges and discharges by DRG by hospital. (Data are currently available through March 31, 2004.) The HSCRC has published reports showing each hospital's charges and number of discharges for common services. (There are only 47 hospitals in Maryland, making such undertakings relatively manageable.) I believe the Commission needs to work toward developing a publicly available database regarding clinical quality.

Conclusion

I believe the outstanding achievements in equity and access and, to a lesser degree, in cost containment, demonstrate that the Maryland legislature created a good

law that has worked for Maryland. The HSCRC has indicated its commitment to improving quality and must give high priority toward improving the incentives for more efficient delivery of outpatient care.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

Chairman HOUGHTON. Thank you, Dr. Cohen. Mr. Morrison, you said in one of your statements something that I think is going to be hanging over us for years and years and years: the connection of charges to cost is tenuous. Are we always going to be arguing about that irrespective of transparency and fairness and the allocation of administrative costs and things like that? Isn't that always going to be a problem with us?

Mr. MORRISON. Mr. Chairman, I believe it is. Just given the nature of the health care industry and the way health care is paid, you will always have arguments about what is the real nature and real relationship of charges to cost. So, yes, no matter what you do, I think we will still have that debate and that argument.

Chairman HOUGHTON. Dr. Cohen, do the uninsured pay the same as the insured?

Mr. COHEN. The uninsured frequently don't pay. The uninsured are charged the same as the insured——

Chairman HOUGHTON. Is the concept that they pay the same as the insured?

Mr. COHEN. The concept is that they are billed the same as the insured, but they don't frequently pay. Since they don't pay and there are resources used in providing them care, the rates that are charged to those who do pay have to cover the costs associated with their care.

Chairman HOUGHTON. So, in effect, when an uninsured patient comes in the door of a hospital, they really don't have any information on how much the service is going to cost them?

Mr. COHEN. In Maryland, they could if they want. I mean, there is a huge amount of data available as to what charges are by hospital, by DRG, and that data is current. As of now, it is available through March of 2004. It is extremely current if they wanted the information and if they ask the hospital what on average it charged, you know, the hospital would tell them if they knew in fact what DRG they were going to be in. Patients don't always know, and their doctors don't always know, exactly what they are going to have.

Chairman HOUGHTON. I guess that is my point. I am sick, I am uninsured, I go into the hospital. I am really not interested in the costs, I am interested in getting cured. There is no sort of general framework which I can use as sort of a cost estimate.

Mr. COHEN. I think if you ask the—I mean, typically, certainly in Maryland, if you ask the hospital what do you charge for this kind of procedure, the hospital could give you an estimate, we charge about from this to this. You never know what kind of complications might arise in a particular instance, so you can't give a firm quote under those circumstances.

Chairman HOUGHTON. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. My questions, really, get to the issues of trying to get our hands around some other

points of fulfilling the nonprofit mission. I am very interested, Mr. Bernd, in your testimony, where you indicate that AHA has kind of set forward a number of things that basically are expected of its members, particularly those enjoying the nonprofit status. Would you expand on that a bit?

Mr. BERND. Certainly. We would expect all of our members to have indigent care policies and to take care of the poor in our communities. We would also expect them to endorse our policies around discounts for patients that fall outside of charitable care and have higher income levels than what is ascertained for charity care normally. We also expect our community institutions, not-for-profit institutions, to serve the larger community through such things as health education, wellness programs, outreach programs. I think the not-for-profit mission is much wider than just providing indigent care, and we expect that of our not-for-profit members.

Mr. POMEROY. The earlier panel, to a person, seemed to agree with the proposition that looking at legitimacy of tax-exempt status solely through the prism of pricing practices was too narrow, there were other things involved. Do you agree with that?

Mr. BERND. I certainly would agree. Our health care is a good example. For instance, 3 years ago, our epidemiologists determined that in our community there was a higher use of antibiotics in our community. We actually started a community-wide campaign with physicians in the community called "Resistance Kills." This program costs us a considerable amount of money, but we were actually able to show in 2 years a significant reduction in the use of antibiotics. In fact, this program has been picked up by other insurance organizations, BlueCross BlueShield in other states. So, I think the not-for-profit mission is much wider than the indigent care, though indigent care is obviously the cornerstone of our not-for-profit mission.

Mr. POMEROY. Mr. Morrison, your experience in nonprofit care delivery—do you have any responses to those questions?

Mr. MORRISON. Yes, sir, I do. Thank you, Congressman. We need to look beyond just the charity care, and I think we do need to look at the broader issues of what is provided as well as the issue of opportunities that may be foregone and the willingness of institutions to undertake services that you would not do if you were just looking at this from a profit motive. Because one of the things that I think you will find historically is that the not-for-profit institutions will take on services that do not necessarily provide a bottom line, but are necessary for the community. Not-for-profit institutions will also take on related issues, such as what we are doing in our community, a looking at the root causes, for instance of health disparities in various ethnic populations, and then working directly with the community to solve those issues.

We are also looking at, and it would be almost counter-intuitive, but we are looking at how do we reduce utilization of health care, how do we reduce chronic care, how can I reduce the admissions to my institution. If I was just in this for the profit, I would not be doing those things. I think there is one of the distinctions that is very, very difficult to measure but that you have to look at over the course of time.

Mr. POMEROY. I have no quarrel at all with the Chairman's statement that this is something we ought to look at once in a while, a tremendous tax expenditure going in this area in terms of revenue foregone to the nonprofit status. It is only appropriate to keep an eye on whether or not the ultimate marketplace performance is as we expect for that status. Is this something within AHA or within the community of hospitals, there is discussion? Do you sense that there is a higher sensitivity in these days about trying to be—making certain that your operations lend a distinct character in light of a nonprofit status? Mr. Bernd? Maybe right across the panel on that one.

Mr. BERND. I would certainly agree with that statement. I think the fact that we have so many uninsured in this country has exacerbated the problem of trying to provide adequate health care. With 44 million people without health insurance, it has become a larger issue for all of us, and how do we take care of those people appropriately and can we give them discounts off these charges we've talked about, which I know our institution certainly does. To give you an example, we have a sliding scale that goes up to 500 percent of the Federal poverty level and give up to 45 percent discounts. This is widely available. We make it available to all of our patients. So, it is an issue that I think is in the forefront and I think it is a healthy discussion and I think it is something we need to talk about openly, and I think this is a really good topic.

Mr. POMEROY. I had asked to go across the panel, but I have taken too much time already, Mr. Chairman. I will yield back.

Chairman HOUGHTON. Thanks very much, Mr. Pomeroy—Chairman Thomas.

Chairman THOMAS. Thank you, Mr. Chairman. The only medical professionals that are truly trying to work themselves out of a job are dentists, based upon the way in which we now treat their area of expertise. I clearly think it is always smart business to assist people in being around longer to utilize services rather than intense interventions for short periods of time so we could always try to get to a bottom line.

I guess I am most concerned about the arguments that the not-for-profits are doing something, for example, the "Resistance Kills" on the antibiotics or the example of attempting to reduce the needed services and that somehow that was associated with your not-for-profit status. Is the reverse, then, to be assumed, that if you were a for-profit you wouldn't care about that? Or would the Hippocratic oath and the commitment to helping people have something to do with that, rather than your not-for-profit status. Mr. Sucher, would you have anything to say about that, since I think you are a for-profit operation?

Mr. SUCHER. I think it is incumbent upon the industry as a whole, regardless of profit or not-for-profit status, that we all seek quality probably even more than you can imagine. We fiercely chase quality every day in everything we do in trying to provide services to our patients, irregardless of our status.

Chairman THOMAS. Let me ask you a follow-up question, because I know pricing has been somewhat of a concern. There was a statement earlier that in fact if you had disclosed prices, would drive prices up. I have difficulty discerning just what a price on a

price list or a master charge list is comprised of. If you ask most businesses, you would start with materials and overhead and add labor and then perhaps put a profit margin in there. Are any of your prices on your price list constructed that way?

Mr. SUCHER. I think they were at one time. I think we have gotten so far away from that and being so reliant on the insurers for establishing procedure-based payments and procedure codes that we now look to them to, really, tell us what they are willing to pay and kind of establish our charges accordingly. We want to make sure we are not charging less than they are willing to pay, certainly.

Chairman THOMAS. Mr. Bernd, do you take a look at materials, labor, overhead, and then add a profit margin, notwithstanding the fact that you are not-for-profit?

Mr. BERND. Well, no, sir, I don't think we look at that that way. I agree with what Mr. Sucher said, it is a matter of negotiated price, so it may or may not reflect your costs.

Chairman THOMAS. Then what is the value of a price list if everything winds up being negotiated?

Mr. BERND. That is a good question. Its relevancy is probably not as much as it used to be.

Chairman THOMAS. Well, I think the proper answer is that it is important when you deal with government as to what payment you are going to get from government. We have seen enormous increases in the price lists, and as you indicate, they have no relationship to the actual payment made. Do you believe that when you negotiate a price, you have a pretty good idea on what your costs of materials, overhead, and labor are so that you won't negotiate a price less than those costs?

Mr. BERND. I would say with commercial payors that is true. With the government, we can't negotiate price.

Chairman THOMAS. Therefore a price list creates a value for you if it continues to go up, notwithstanding the fact it has no relationship to what you are really getting compensated for by other players. Is that one of the reasons why the price list goes up?

Mr. BERND. Probably.

Chairman THOMAS. Probably? Do you believe that if prices were disclosed it would drive prices higher?

Mr. BERND. We disclose our prices to our customers. Again, they are very complex, but we do disclose them.

Chairman THOMAS. Do you believe that has caused pressure to drive the prices higher?

Mr. BERND. No.

Chairman THOMAS. If all hospitals disclosed prices, much as you do for virtually any other commodity or service, would that be a benefit to the consumer, or would it make it more difficult for the consumer to make a decision?

Mr. BERND. I think we should be totally transparent on our pricing to all of our customers.

Chairman THOMAS. Okay. In trying to determine structures between not-for-profit and for-profit, Mr. Bernd, I notice that on the Form 990 filed by Sentara Health Care in 2002, that in your role as the president and chief executive officer, you received $908,684, with an additional $236,000 in deferred compensation and $12,840

in expenses, which is $1,160,000 in salary and deferred compensation. Have you ever done comparisons with for-profit systems, and do you believe that that is kind of where the pricing for executives in your capacity, given your responsibilities, are paid?

Mr. BERND. Well, first of all, I do not set my own salary. I have an independent board of directors made up of community——

Chairman THOMAS. I didn't ask you if you set your own salary. Is the number incorrect, the $1.16 million?

Mr. BERND. I believe it is accurate.

Chairman THOMAS. Then my question was do you believe that is comparable across the board between for-profit and not-for-profit with people in your commensurate responsibility position?

Mr. BERND. I don't know.

Chairman THOMAS. You have never done comparative salary and compensation examinations?

Mr. BERND. Personally, no. We hire an independent organization that does that for the board of directors, under their control.

Chairman THOMAS. Last question, for all of you. We are looking at the question of whether or not we should maintain a tax preference for a particular type of hospital structure. Everyone believes we should take care of the uninsured. What, to you, is a higher use of taxpayer money: should we deny tax preference and use that to take care of the uninsured, or would you prefer to retain your tax preference and we set up a set of structures which guarantee that the uninsured are taken care of under the charity or the community label for which you receive the tax preference? We can just start with you, Mr. Bernd. We will go down the panel.

Mr. BERND. That is a very long question. Can you repeat it for me, please? I am sorry.

Chairman THOMAS. It is very simple. Everyone has argued that because they received a nonprofit benefit, we are doing charitable things, although once you examine it there are some folks, especially Dr. Cohen, about the fact that they get charged, we don't get collected. We have had bad debt. We've got a very elaborate superstructure to try to deal with this. Everyone says if we could get the uninsured insured, that would really solve a lot of problems.

We are looking at an enormous amount of money that is currently going, 41 percent of the tax expenditures under 501(c), to hospitals which originally was for charity and now community. My assumption was that maybe some of the uninsured got picked up that way and what we have heard were very minuscule examples of that effort which should pass muster.

Very simple choice: in trying to make policy, would you prefer we repeal the tax-exempt status under 501(c) for any hospital and apply the money saved to perfect an insurance package for the uninsured? That would solve your problem, because now the people who are coming to your door are paying you and you can run more on a for-profit structure in which we might be able to adjust whether or not you make a profit. Or would you prefer, do you think it is a better societal service to keep the not-for-profit tax-preferred status, but you are going to say somebody else should worry about the uninsured, don't take it out of our money, when in fact the reason for creating the tax preference was for charity and community work. So, would you support eliminating the tax-preferred status

and solving the uninsured problem with that money? Would that be a better use of the taxpayers' money than the way it is currently spent?

Mr. BERND. No, I don't believe so. I think, as we talked about it, not-for-profit status and charitable has more to do than with indigent care and patients that don't have insurance, it has to do with community mission, community assets. Not-for-profit status is wider than just that issue.

Chairman THOMAS. The board that sets your salary may have some impact on the $1.16 million. Mr. Sucher, what is your position?

Mr. SUCHER. Obviously, being from the for-profit side, we would much prefer a level playingfield in all of our competitive aspects. We do provide much uncompensated care as well, for which we get nothing as far as benefit. So, we would really prefer to see something done regarding those who are uninsured in lieu of a tax break.

Chairman THOMAS. You realize that your testimony just shocks me in terms of the position that you have assumed.

Mr. SUCHER. Yes, sir.

Chairman THOMAS. Mr. Morrison.

Mr. MORRISON. My testimony will also shock you. It would be my consideration that we should maintain the tax-exempt status for long-term considerations. While there may be some short-term issues that we are facing with the uninsured, I think the stability of the health care system long-term has been shown that it is served by the tax-exempt nature of hospitals. It will continue to be served by the tax-exempt nature of hospitals.

Chairman THOMAS. Dr. Cohen.

Mr. COHEN. Well, my priority is that extending coverage to the uninsured is the most important option out there for the limited resources that we have. However, tax breaks don't provide money. They allow hospitals to not pay money and if they suddenly have to pay that money, then Medicare, for example, would have to pay rates which paid their fair share of that burden that you then placed on the hospitals. So, if I had to answer your question, it would be first extend coverage. Then, if you eliminate the tax breaks, make sure that Medicare and Medicaid pay their fair share of the added costs that would be placed on hospitals by having to pay those taxes.

Chairman THOMAS. Thank you very much, Dr. Cohen, because that underscores my point. I would say to my friend from North Dakota, prices are fundamental to dealing with the question of not-for-profit or profit, because nobody can tell you how they determine what their prices are other than dealing with the government on payments that are not realistic and don't deal with the cost of materials, overhead, labor, or profit. If in fact we are going to talk about trying to serve the uninsured, and in fact the price list is created for the purpose of getting more money out of taxpayers, i.e., the Medicare and the Medicaid payments, what it actually costs to do what they do is essential in looking at limited dollars, whether it is through tax-preferred structure or payments for real costs. If you don't know what they are, you cannot deal with the question responsibly as a legislator.

When you are talking about tax-preferred status and what requirements need to be performed for that, you need to start with how much does it cost to do business. I would be more than willing to submit for the record the list of CEOs and the payment they receive between the not-for-profit and the for-profit on comparable hospital responsibility sizes. There is a significant difference in that area alone. You wonder what other prices would be reflected if you had an accurate ability to determine what materials, overhead, cost, small margin of profit, notwithstanding the fact they are not for-profit, would produce between the two structures. Then you can determine the relative value of the tax-exempt. You can determine whether or not we ought to create a real system where you get the money out of the services that you deliver and that we make sure everybody gets a minimum compensation from that structure, and augmented if necessary to deliver the services.

Psychic value of believing you are serving the community doesn't necessarily reflect the real value of the tax-deferred that does not get counted when we are dealing with the uninsured. Pricing is essential to completing the understanding of that model. Thank you, Mr. Chairman.

[The information follows:]

Comparison of Not-For-Profit and For-Profit Hospital Executive Compensation

Hospital System	Hospitals	Beds	Compensation
Top 5 Not-For-Profit President and CEO Catholic Healthcare West San Francisco, CA	38	8,413	$1,969,575
President and CEO Providence Health System Seattle, WA	18	3,306	$1,421,000
CEO and Director Sutter Health Sacramento, CA	24	5,383	$1,203,005
President and CEO Adventist Health System West Roseville, CA	19	2,634	$ 971,410
President and CEO Sioux Valley Hospitals Sioux Falls, SD	26	1,902	$ 398,303

Source: 2002 990 IRS Forms for the 5 largest non-profit systems, excluding decentralized systems. It includes salaries, deferred compensation, expenses and other allowances.

Hospital System	Hospitals	Beds	Compensation
For-Profit President and CEO Health Management Associates Brentwood, TN	43	5,520	$1,404,203
Chairman, President and CEO Lifepoint Hospitals Brentwood, TN	21	1,968	$1,124,615
Chairman, President and CEO			

Hospital System	Hospitals	Beds	Compensation
Iasis Healthcare Corp. Franklin, TN	14	2,028	$1,086,449
CEO Ardent Health Services Nashville, TN	23	2,125	$ 525,001
Senior Vice President* Group Operations Community Health Systems Brentwood, TN	20	1,692	$ 477,980

*Senior Vice President is used for comparison purposes. With 72 hospitals, the Community system would be significantly larger than the not-for-profit systems.

Source: To compare systems of similar size, this includes the five smallest public for-profit systems. 2002 data, SEC 14(A) and Annual Reports. It includes salaries, bonuses and deferred compensation.

Chairman HOUGHTON. Thank you. Mr. Cardin?

Mr. CARDIN. Thank you, Mr. Chairman. As I listened to Chairman Thomas' and Dr. Cohen's exchange, one very important point—and that is if we were to eliminate the tax-preferred status, then it would be incumbent upon the extra costs associated with that being shared fairly. In Maryland, we can do that because we have an all-payor structure. In the rest of Nation, I doubt that would occur, because of the way the prices are negotiated based upon market share, based upon the size of the entity that is negotiating with the hospital. If you are larger and you have a bigger share of that hospital's market, you can command a larger discount. That is just basic economics.

I apologize for not being here during the presentations. I was actually, on behalf of the Democrats, managing two Ways and Means bills that were on the floor. I first want to acknowledge Dr. Cohen, because he is the person in our State responsible for the way that we were able to administer an all-payor system and still have one today. Many other States tried; Maryland is the only State that has been able to succeed. The reason is that Dr. Cohen established a regulatory system that was immune from traditional political involvement. As a legislator in Maryland, I never would have thought to interfere with the rate-setting discretion of our commission. That is a credit to Dr. Cohen and the confidence that we had in Maryland in the manner in which he administered the system.

I think most people here don't understand what an all-payor system is. All-payor system is not a regulatory system that establishes a rate that hospitals can charge for a particular service. It establishes a rate that a hospital can charge for service, which is different among hospitals but the same for all the payors within that hospital. So, it makes no difference whether you are Medicaid or Medicare or private insurer or uninsured when you walk in the door. Basically, you are going to be charged the same amount for the services that the hospital performs. Under that theory—and maybe this is theory; I hope it is not—that you want to provide identical services to everyone who walks through your door for the same type of condition, that there is no difference in quality if you walk in with a Medicare card or you walk in with a BlueCross BlueShield card, into a hospital, that you are still going to get the

same quality attention. Therefore, why should there be a difference in fee?

Of course, the second major advantage in the Maryland all-payor system is that we can get Medicaid and Medicare to pay its fair share, whereas in the other States in the Nation that is a little more difficult and complicated process. There is one more advantage, I might say, to the hospital community here. I have been told there is either one or two people in CMS that deal with the Maryland waiver. So, we don't have to deal with CMS, even though it is located in the State of Maryland, a great organization—at least the employees are great people. It does give you that advantage.

So, I am just—particularly when you look at the nonprofit, the tax-preferred community, where you have a role to play in a community itself, why aren't you proposing more of this all-payor concept so that you can get a fair distribution of the costs? Why don't I hear more of my colleagues around the Nation talk about returning to some form of an all-payor system in order to deal with this dilemma of treating all the users of a hospital fairly?

Mr. BERND. As you mention, the system in Maryland has been very successful. In fact, talking to Dick Davidson about this, who was there when the system started, and how successful it has been, he said that there have been 15 other States that have tried it and have failed. The uniqueness of the Maryland system, as you know, is it is limited to 47 hospitals which get reviewed independently each year. There is an independent commission that is set up and I guess the biggest hurdle is Medicare and Medicaid paying full costs and the State being allowed by Medicare to set those rates.

For instance, we looked at if you set an all-payor system in the State of California, for instance, just to duplicate what has happened with Medicare in the State of Maryland, you would have to increase the California medical reimbursement to hospitals in California by 40 percent. So, you have such disparities in reimbursement by Federal programs that it makes it very——

Mr. CARDIN. I am not sure that is totally accurate. Why don't we start with North Dakota, a little bit more manageable State than California. I mean, there are a lot of other States we could pick other than California. California is a country unto itself. I understand the unique concerns. Dr. Cohen, is it possible that we could export, or are just so grateful that we have this waiver we are afraid if any other State looks at it, it could jeopardize what we are doing in Maryland?

Mr. COHEN. I think—first of all, thank you very much for the kind words. I think one of the issues, when Maryland started, Medicaid was cost-based reimbursement. You were in the State legislature at the time when we negotiated the waiver, as I recall. We explained to the Maryland legislature that it was going to cost an additional 2 percent to pay their fair share. That is all it was going to be back then and the Maryland legislature said we are happy to pay our fair share and they adjusted the budget accordingly and went with the waiver. It is not clear to me that a lot of other States are willing to pay their fair share for Medicaid right now.

There are tremendous equity advantages and huge access advantages. In my written testimony, I didn't have time to present it all, but I did indicate the fact that in Maryland everyone has access

to all the hospitals. We had Legal Aid testify that they had no dumping cases. Hospitals were, you know, willing to treat people and uncompensated care is equitably financed and it is spread among all hospitals. There aren't any charity care hospitals as such. There are hospitals that provide a fair bit of charity care, but the range is only around 2 to 13, with the average of being around 7.5, I mean, which is—the average is high because there is good access, but no one hospital is all that high.

Mr. CARDIN. I appreciate that. I would conclude by saying you are either going to pay now or pay later, and it is a lot less expensive if you pay up front and give access to quality hospital care to all your constituents. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you, Mr. Cardin. Mr. Johnson?

Mr. JOHNSON. Thank you, Mr. Chairman. I am wondering if patients who have high-deductible plans or maybe the new HSAs would be billed as those who are insured or those who are uninsured, since they are paying out of the pocket.

Mr. COHEN. I can tell you that in Maryland they are all billed the same. So, the answer is they are all billed the same.

Mr. JOHNSON. For Maryland. I doubt that is the same with the rest of them.

Mr. SUCHER. It is one of our concerns that those type plans, and you are starting to see them proliferate in a less organized manner across the Internet offering insurance for $50 a month, things like that. All those plans do is offer access to that payor's discounts, which gets them, you know, maybe 70 percent of charges or 80 percent of charges. It gets them a discount, but that is all. So, they are billed the entire rate minus the discount that whatever plan they have signed up for entitles them to, and then they are expected to pay that discounted rate.

Mr. JOHNSON. Based on the insurer?

Mr. SUCHER. Based on the supposed insurer that is backing them, of course, who is not just giving them access to their rates.

Mr. JOHNSON. Which is providing that type of insurance.

Mr. SUCHER. Right, and of course our concern with that is that the payor can't afford to pay 70 percent any more than they could pay 100. So, we get very little from that patient as well.

Mr. JOHNSON. Let me ask you this question. Since physicians decide on what treatment is needed, do they know what the treatment costs every time and how do you think that affects total cost?

Mr. MORRISON. Congressman, that is an excellent question. We have in our organization undertaken some efforts to try to educate our physicians on what particular tests cost, what particular drugs cost, and as we are able to increase their sensitivity, they do make different decisions as to the selection of the drug or whether that test is really, really necessary. I am not sure it is a practice across the board, but I think it is something that hospitals ought to consider because doctors are a little inoculated from the impact of their decisions upon the cost of care.

Mr. JOHNSON. Is every hospital different? Go ahead.

Mr. SUCHER. Well, we are the same way. We very much know what our costs are and provide the information to our physicians regularly and encourage them to understand that and know what they can do to change that as well. Contrary to one of Mr. Thom-

as's earlier comments, I think hospitals today generally do know their costs of procedures. We know very precisely what our average costs for most things we do are. The trick is getting that from what we know the cost to be to some sensible charge structure, when—you know, I can't get anybody to pay any more to deliver a baby; where I lose money, I am sure not going to go in and say, gosh, I am going to discount my prices over here to come closer to costs when I can't raise the other side of the equation.

Mr. BERND. I would just add that I think one of the most effective tools to provide effective care is working with physicians to look at the best treatment models for patients' illnesses and try to streamline the care process, which takes into account efficiency and effectiveness of the care, and using disease-based information that is available on what the best treatments are for patients with certain illnesses. I think that is really a key to long-term success of trying to hold down costs.

Mr. JOHNSON. Do you think the for-profits or not-for-profits provide better physicians, facilities, and response than one or the other? You know, why do you think specialty hospitals popped up? According to the physicians I have talked to, they said the hospitals were not giving them the operating time when they needed it.

Mr. BERND. I think that facilities between not-for-profits and for-profits are very similar. I think the specialty hospitals in some places have been brought forward due to lack of capacity. I think in others it has something to do with profit motive. It just depends upon the situation, and I think we have talked—we heard earlier the testimony about the fact that certain procedures in hospitals are more profitable than others, and if you do take those out of an institution you can do well financially. So, it is a complex issue.

Mr. JOHNSON. Yes, sir?

Mr. MORRISON. I think that the first place you really do have to look is that, the financial incentives that are there in the boutique hospitals and with the physician involvement, you do have the prospect of taking the more profitable or the easy cases to someplace where you have an investment, and taking the more difficult cases where you do not. There may be instances where there are capacity issues, but those are generally met by the not-for-profit institutions. The issue is one of business and financial motive.

Mr. JOHNSON. Thank you very much. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you. I am going to turn to Mr. Weller in a moment, but before I do, Mr. Bernd, please repeat your answer to one of Mr. Johnson's questions regarding some of the key elements of keeping down long-term costs.

Mr. BERND. Well, I think using evidence-based medicine and trying to work with physicians to put into place treatment protocols and care pathways are very effective. I know we have had a lot of success in Norfolk with those, where you try to use evidence that is there on how to best treat a patient and follow a particular pathway. It is very effective in not only reducing cost, but having more effective care.

Other things that are happening is we put in remotely controlled intensive care unit monitoring, where patients are monitored in in-

tensive care units around the clock. You have immediate intervention with patients in trouble and we have seen a dramatic decrease in mortality and a decrease in cost for the investment of this technology.

So, I think you are beginning to see some very good breakthroughs. Another good example are software systems that are now in place that, for instance, will provide to the clinicians when they order a particular drug, will show them how it interacts with other drugs, what counter-indications there are, lab test results. So, I think we are on the cusp of having some tremendous breakthroughs in both quality and cost reductions.

Chairman HOUGHTON. Is this something which would lend itself, really, to sort of regional repricing and re-estimation, or is it something which could be right across the country?

Mr. BERND. I think it is something that could be very beneficial across the country and I think, the other problem we have with prices and hospitals and health care obviously has to do with increased utilization and the fact that we are getting older as a society. I hope these interventions and changes in technology will help us decrease the increases, which have been very high lately.

Chairman HOUGHTON. Thanks very much. Mr. Weller?

Mr. WELLER. Thank you, Mr. Chairman, and thank you for the opportunity to ask some questions. You know, Mr. Bernd, representing the AHA, as you know in Illinois, as is in the case of my own district, the vast majority of hospitals are not-for-profits.

Mr. BERND. All right.

Mr. WELLER. The district that I represent in the south suburbs, every hospital is a not-for-profit. They usually are the largest employer in town, if not competing with the usual locally, the school district, and they also provide service to my communities. I would note, one thing I am particularly proud of is that all my hospitals have a record of serving the health care needs of people in our communities regardless of their ability to pay, their insurance status or even their citizenship status.

There is almost 1.7 million Illinoisans, many of them immigrants and the working poor that have no health insurance. Yet all my hospitals, as I have seen in the records that I have, have been there when they have needed medical care. This past year, Illinois hospitals provided more than $2 billion annually in medical care for which they did not receive one dime in reimbursement.

I would note one system which serves much of my district, Provena Hospital System in Illinois, provides $6.5 million in free care and last year lost $32.8 million on Medicaid services that they provided to my constituents. One particular hospital of Provena, St. Joseph's in Joliet, provides care at no cost to the Will-Grundy free clinic and donated a quarter of a million dollars to the local YMCA to build a health care facility.

As I have seen, Illinois hospitals take their commitment to charity care pretty seriously. In fact, last year the Integrated Healthcare Association (IHA) and the Metropolitan Chicago Health Care Council developed guidelines in charity care and collection practices for the uninsured that are designed to be patient-friendly. Mr. Bernd, I would like to get your perspective on these guidelines.

The guidelines include a number of basic principles. Uninsured patients receive free care if they are at or below 100 percent of Federal poverty. Discounts provided to patients with incomes between 100 and 200 percent of Federal poverty. Hospitals work with patients receiving discounts to develop a reasonable payment plan. Hospitals do not take legal action against charity care patients who have demonstrated that they do not have sufficient income or assets to meet their financial obligations.

Obviously, in order for these hospitals to serve, they also have to survive financially. Illinois hospitals such as Provena have demonstrated that they can serve these communities, particularly those with limited access to care. They tend to be the poorer non-citizen patients.

The question I have for you, Mr. Bernd, is, you know, you are coming before us today with a national perspective. I have shared with you the initiatives of the Illinois hospital community. I was wondering what are your thoughts on charity care guidelines such as those that we have in Illinois?

Mr. BERND. Actually, those guidelines that you have presented, endorsed by the Illinois Hospital Association, have come from the collaboration with the AHA, and actually we are asking every hospital in the union to endorse those particular guidelines. In fact, over 2,500 hospitals have endorsed those specific guidelines. I think they are excellent. I personally see them as a minimum requirement for our members. In fact, I was the first—we were the first institution that signed those. I think that is very good and I think it is something that is really needed.

Mr. WELLER. So, essentially these guidelines are in process of being adopted nationwide? How many States adopted?

Mr. BERND. Well, again, 2,500 of our 5,500 members have adopted it and we have only been at this about a month. So, we are very encouraged by the results, and we expect to have 100 percent of our members across all States endorse this.

Mr. WELLER. You had mentioned that you see these guidelines as the bottom line. How would you improve them?

Mr. BERND. Well, for instance, my own health care institution, we provide discounts up to 500 percent of the Federal poverty. So, that is our commitment to our community. I think it would differ in each community, depending upon the needs of the community, the types of population, the number of poor you have, wage index. I think you need to tailor them by each community.

Mr. WELLER. You know, Congress always comes up with great ideas, as you know.

Mr. BERND. Yes, sir.

Mr. WELLER. I was just wondering, is there a role for Congress in developing these kinds of guidelines?

Mr. BERND. I would hope what you have done, which is to really publicly advocate what your member hospitals have done from your district. That is really outstanding. I am sure we will report that in our National news and the fact that our congressmen are supporting us in this effort. I think the real thing we all need to work on and the thing that we have all talked about today is the fact that there are now 44 million Americans without health insurance and the strains it is putting on all the systems, our health care sys-

tems. It is a real problem. It is now beginning to hit the middle class, and it really is a problem.

Mr. WELLER. Thank you, Mr. Bernd.

Mr. BERND. Yes, sir.

Mr. WELLER. Thank you, Mr. Chairman.

Chairman HOUGHTON. Mr. Pomeroy.

Mr. POMEROY. Mr. Chairman, I just have a request relative to the issue of whether people with HSAs that carry health insurance over the top of their HSA first-tier exposure are able to access the discounted arrangements made by the underlying insurance company for their portion of the first-tier costs. We inquired of the largest players in the health insurance industry. I have a response from BlueCross BlueShield. Others are sought from the United Health Group. We would ask that these be allowed as part of the record of this hearing, Mr. Chairman.

Chairman HOUGHTON. Absolutely. Mr. Portman.

[The information was not received at the time of printing]

Mr. PORTMAN. Thank you, Mr. Chairman, and I thank the panelists for giving us some good information today. I was here for the earlier panel and then had a meeting in between. In that meeting, it happened to have been with somebody who works for one of our hospitals back home. I talked earlier in the hearing about the fact that we have three major networks in greater Cincinnati, Ohio. They are all three nonprofit. They all provide charity care, of course, but also benefits to the community beyond that.

This person in particular was talking about billing. This was a good opportunity coincidentally to hear something from somebody who in this case is a relatively junior member of the billing staff, and she was talking about some of the very issues that you struggle with every day, including the fact that many of the patients are not able to access insured coverage, so they come in either under Medicaid or with no health care and no compensation for their care. They don't tell the hospital that. So, the collection process begins, it becomes very complicated. Reminds me a little bit of the IRS collection process, where often the left hand has not known what the right hand has been doing—although that is better now—and in the end there is a lot of wasted cost and effort and very little benefit to the hospital in the end because the person doesn't have the resources.

My first question would be is the current system of billing serving the hospitals well, and how could it be improved? Particularly, what recommendations would you have for this panel in terms of dealing with the billing side of things strictly as it relates to uninsured or under-insured patients? Mr. Bernd, maybe you want to start with that.

Mr. BERND. I think the present billing system doesn't serve the patients and the hospitals very well. It is very complex. We deal with over 100, 200 different insurance companies. I think some of the things we could work on are standardization of requests from insurance companies, standardization of information that is needed. It is a very difficult system and it is very complex. I think you heard about that today with pricing in the other areas. So, we could use some help in that area.

Mr. PORTMAN. Well, with regard to standardization, we have talked about that for years. With regard to the Federal side, I know we do more electronic billing now, which I am told is more efficient. I hope you all believe that. With regard to the private sector side, how would you get to that uniform or standardization of billing? Should that be a Federal mandate, are you suggesting? How would you get to the point that I think everybody agrees would be helpful to reduce the administrative costs?

Mr. BERND. Well, I would like to see the private industry do that, but maybe encouragement by Committees such as this to say that we need to do it on the private basis would spur us on to do that. We need the cooperation of all these various insurance companies.

Mr. PORTMAN. Let me ask the second question, and gentlemen, jump in as to my first one, too. Do you believe that hospitals are well-served by a system that bills consumers amounts unrelated to what their insurer actually pays? Is that something that is good for hospitals? Mr. Morrison, you seem eager to answer that.

Mr. MORRISON. I am eager to answer that. Thank you, Congressman. I am not sure that we are well-served by that, because I think, if we know up front if you are insured, that your insurance company is going to pay something substantially less than, essentially, our rack rate, it does create a significant amount of confusion to that enrollee if he were to get a bill for $20,000. He doesn't know is he going to owe a portion of this? What is this bill all about? His insurance company comes back and says, you know, we paid $10,000, you owe $500—is the hospital going to come back at me to get the balance? Which we are precluded from doing because there is not balance billing. I think if we are required to send out a detailed bill when there is no expectation that an individual is going to pay off that detailed bill, it does create a tremendous amount of confusion and it creates a lot of cost. It is unnecessary.

Mr. PORTMAN. Mr. Sucher.

Mr. SUCHER. I think one of the greatest injustices to hospitals from the current system is that the insurers don't really show the insured what they did in fact pay. For that same $20,000 bill he just cited, if we get $10,000, for all the patient knows, they paid $19,500, because all they then get is a statement that shows the bill is taken care of except there is $500 left. It is very hard, then, to collect that $500 from the patient when he thinks we have already gotten $19,500, when in fact we have only gotten $8,000 or $10,000. So, it is a very disserving system for all concerned.

Mr. PORTMAN. So, more transparency, we talked about earlier, even in billing—simplifying it and doing as much at the front end as possible to determine what the insurer can pay, will pay, and what the costs are would be helpful, it seems to me.

Mr. COHEN. Mr. Portman, I believe that the very high charges are a major problem for managed care and insurance companies. Many admissions are through the emergency room. If you don't have a contract with the hospital and, for those patients who go through the emergency room, if you are responsible for paying charges, it is an exceedingly high amount. The result is that it puts inappropriate pressure on payors to negotiate with virtually every hospital. I think that puts too much of the balance of power in the

hospital arena in regard to the negotiations, and that is something to consider.

Mr. PORTMAN. Thank you, Dr. Cohen. One final question. I would ask for this response in writing, since my time has expired. Mr. Morrison, Florida law, as you know, hospitals are required upon request to provide the estimated charges for a hospital stay or a treatment. If you could give us your written response as to what the positives and negatives are to that—and for that matter, any other panelists who have thoughts on that as a system that could be used in other States. Again, gentlemen, thank you for your testimony. Thank you, Mr. Chairman.

Chairman HOUGHTON. Thank you. I just have one final question. Mr. Sucher, I am interested in a simplification, reduction, making it understandable. This is not just in health care, but in a whole variety of other things. Are there some immediate changes we could use to simplify the hospital billing system, like right now?

Mr. SUCHER. I wish there were. I would certainly be glad to offer something if there was. The simplest thing is, as he just said, doing some kind of a lump-sum billing that allows, like Medicare for DRGs, and avoid the whole detail-billing process. I don't think that is a quick solution because there is too much invested in that process from so many things, to make a quick change in that.

Chairman HOUGHTON. Is that possible on a State-by-State basis or would it have to be a national?

Mr. SUCHER. I think you would prefer it was national rather than State-by-State. I mean, demonstration projects oftentimes can get something done, so——

Chairman HOUGHTON. All right. Okay, well, thank you very much. Appreciate your testimony. It has been a great day. Onward and upward to another session.

[Whereupon, at 1:20 p.m., the hearing was adjourned.]

[Questions submitted from Chairman Houghton to Ms. Davis, Mr. Bernd, and Mr. Cohen, and their responses follow:]

Question from Chairman Amo Houghton to Ms. Karen Davis

Question: You stated to the Committee that you have quantitative estimates of the community benefits for medical education, standby capacity and charity care. I ask that you provide those estimates to the Committee. In addition, you stated that on the whole it was enough to justify the tax difference. I ask that you provide that evidence to the Committee.

Answer: Like other nonprofits, nonprofit hospitals are ordinarily exempt from Federal income taxes. As a rule, they receive their tax-exempt status under section 501(c)(3) of the Internal Revenue Service Code which applies to organizations with religious, charitable, public safety testing, scientific, literary, and educational purposes. Because the Code has never explicitly included medical organizations, hospitals and other health care organizations have qualified under the term "charitable."[1] The status also means that hospitals will have access to tax-free bonds, can receive tax deductible donations from donors, and will have a greater likelihood of being exempt from various state and local taxes.[2]

An IRS ruling in 1969 explicitly defined the criteria for hospitals' tax exemption.[3]

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[1] D.M. Fox and D.C. Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," *Journal of Health Politics, Policy and Law*, 16 no.2 (1991)251–279.

[2] M. Schlesinger, B. Gray, E. Bradley, "Charity and Community: The Role of Nonprofit Ownership in a Managed Care System," *Journal of Health Politics, Policy and Law*, 21 no.4 (1996)697–751.

[3] D.M. Fox and D.C. Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," *Journal of Health Politics, Policy and Law*, 16 no.2 (1991)251–279.

In particular, nonprofit hospitals were to operate a full-time emergency room and could not deny emergency care to patients. In the ruling, charitable activities, in the context of health care, were those that generally promoted health and thus benefited the community as a whole.

A broad range of activities undertaken by nonprofit and public health care institutions have been identified as community benefits. Schlesinger and colleagues, for example, identified over 30 different community benefit activities that health care institutions engage in.[4] Such activities include those with public good attributes such as teaching and research which benefit entire communities, those that have positive spillover effects such as programs designed to prevent disease, and those activities, like outreach to high risk patient groups, which have little likelihood of being undertaken by profit making institutions. Other types of community benefit are community involvement in governance and a refusal to exploit information asymmetries endemic to the health services market such as imperfect information on the part of patients.

Academic medical centers and teaching hospitals, the vast majority of which are public and private non-profit institutions, pursue several unique missions that benefit the broader community. Those missions include graduate medical education, biomedical research, and the maintenance of standby capacity for highly specialized care to medically complex patients. Research conducted by Lane Koenig, Al Dobson and others for the Commonwealth Fund's Task Force on Academic Health Centers and published in a late 2003 article in *Health Affairs* estimated that the costs of these three missions alone amounted to $27.2 billion in 2002.[5] Of that total, $16.4 billion went to graduate medical education, $9.6 billion financed stand-by capacity, and $1.2 billion funded research. Also see Appendix A for a summary of work on this issue in the final report of the Commonwealth Fund Task Force on Academic Health Centers.

It should be noted that these estimates are based on standby capacity for highly specialized care such as burn units and trauma care. They do not include future threats including the value to communities of having a hospital equipped to deal with terrorist attacks or natural threats such as a SARS-like epidemic. Most communities would willingly forego property taxes on local nonprofit hospitals in exchange for assurance that this capacity was available—even if an occasion to use it never materialized.

With respect to charity care, as I indicated in my testimony,[6] a significant amount of research has shown that nonprofit hospitals are more likely to care for uninsured patients than are for-profit hospitals.[7] Further, academic health centers are more likely to care for such patients than are community hospitals.[8] In recent years, care for the uninsured has been increasingly concentrated in fewer institutions willing to provide that care. Public academic health center hospitals provide the highest levels of charity care among all hospitals, while private nonprofit academic health centers provide twice as much free care as other private hospitals.

Recent work by Jack Hadley and John Holahan found that in 2001, private and public health care providers spent an estimated $35 billion a year on care for uninsured patients that went uncompensated (i.e, that was not paid for by patients or

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[4] M. Schlesinger, B. Gray, E. Bradley, "Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System," *Journal of Health Politics, Policy and Law*, 21 no.4 (1996) 697–751.

[5] L. Koenig, A. Dobson, S. Ho, J.M. Siegel, D.Blumenthal, J.S. Weissman, "Estimating the Mission-Related Costs of Teaching Hospitals," Health Affairs (November/December 2003):112–122.

[6] Karen Davis, *Hospital Pricing Behavior and Patient Financial Risk*, Invited Testimony, Subcommittee on Oversight, Committee on Ways and Means, Hearing on "Pricing Practices of Hospitals," June 22, 2004.

[7] L.S. Lewin, T.J. Eckels, and L.B. Miller, "Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals," *The New England Journal of Medicine,* 1212–1215,May 5, 1988; Bradford H. Gray, "Conversion of HMOs and Hospitals: What's at Stake," *Health Affairs,* 29–47, March/April, 1997; Gary Claxton, Judith Feder, David Shactman, and Stuart Altman, "Public Policy Issues in Nonprofit Conversions: An Overview," *Health Affairs* 9–28, March/April 1997; David Shactman and Stuart H. Altman, "The Impact of Hospital Conversions on the Healthcare Safety Net," in Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields (eds.), *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* Health Administration Press; Institute of Medicine Committee on Implications of For-Profit Enterprise in Health Care, Bradford H. Gray (ed.), *For-Profit Enterprise in Health Care*, National Academy Press, 1986.

[8] Commonwealth Fund Task Force on Academic Health Centers, *A Shared Responsibility: AcademicHealthCenters and the Provision of Care to the Poor and Uninsured,* Commonwealth Fund, April 2001.

private or public insurers).[9] Hospitals delivered about two-thirds of total uncompensated care or a total of about $23.6 billion.

I have only identified some of the quantifiable benefits that flow to communities and the nation as a whole from nonprofit and public hospitals. Clearly such community benefit activities yield considerable value to the U.S. health care system. Nonprofit hospitals' tax exempt status should be considered in the context of the overall framework of our health care system and its unique needs. Highly fragmented, it relies heavily on local health care institutions to provide a wide range of health care services, not all of them profitable, to an increasingly diverse population, as well as the education and training of health care professionals. Reliance on nonprofit health care institutions has likely helped the system maintain its high degree of decentralization and privatization while still managing to provide at least some of the services that traditionally for-profit entities might have failed to provide. Serious debate about the tax-exempt status of hospitals really has to engage the larger, more fundamental question of the how the United States wants to finance the health care of its population.

Appendix A

Excerpt from *Envisioning the Future of Academic Health Centers: Final Report of The Commonwealth Fund Task Force on Academic Health Centers*, New York: The Commonwealth Fund, February 2003; 7–9. (Fund Publication #600) Available at www.cmwf.org.

Clinical Costs of Mission-Related Activities in Academic Health Center Hospitals

The conduct of mission-related activities in AHCs and other health care institutions is often associated with extra expenses that are not compensated in competitive health care markets. These extra expenses are manifested in part as higher clinical costs at AHCs. The performance of some missions, such as educating medical students and residents and conducting clinical research, makes the provision of care less efficient or requires extra work and the hiring of extra staff.

According to a recent analysis by The Lewin Group, the cost per case for AHC hospitals ($8,548) was higher than the cost per case for other teaching hospitals ($6,047) and for other urban, community hospitals ($5,238) in fiscal year 1998 (Figure 3).[10] The Lewin Group analysis decomposed these total cost per case estimates to provide separate cost estimates for each of the mission-related categories for fiscal year 1998. After accounting for differences in wages, case mix, and other factors that influence cost per case, mission-related costs averaged $2,360, or 28 percent of total costs, for AHC hospitals. By comparison, mission-related costs for other teaching hospitals accounted for only 11 percent ($674) of total costs. For AHC hospitals, stand-by capacity (defined as the capacity to provide high-technology or intensive services whose availability is essential to a modern health care system, but that are not always in use) accounted for the largest component of mission-related costs (45 percent), with indirect medical education and research representing 42 percent and 13 percent of total mission-related costs, respectively (Figure 4). After updating these cost estimates to 2002 values using the Centers for Medicare and Medicaid Services Prospective Payment System Hospital Input Price Index, total mission-related costs, including medical education, are estimated to be $11.4 billion for AHC hospitals and $27.2 billion for all teaching hospitals (Table 1).

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[9] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* Web Exclusive (12 February 2003): W3–66—W3–81.

[10] Lane Koenig et al., "Mission-Related Costs of Teaching Hospitals: Estimates of Graduate Medical Education, Clinical Research, and Stand-by Capacity" (Unpublished manuscript, November 2002).

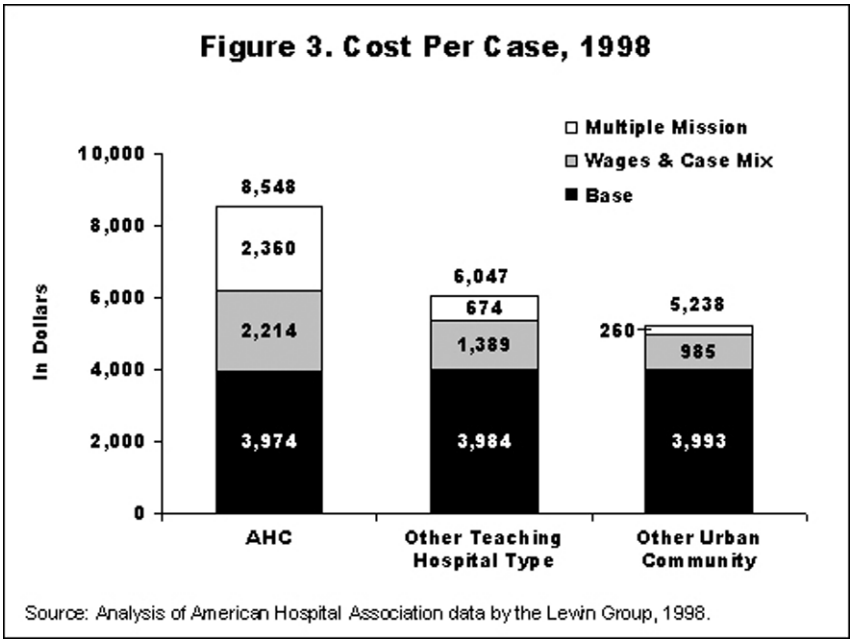
Figure 3. Cost Per Case, 1998
Multiple Mission
Wages & Case Mix
Base
In Dollars
10,000
8,000
6,000
4,000
2,000
0
8,548
2,360
2,214
3,974
6,047
674
1,389
3,984
5,238
260
985
3,993
AHC
Other Teaching Hospital Type
Other Urban Community
Source: Analysis of American Hospital Association data by the Lewin Group, 1998.

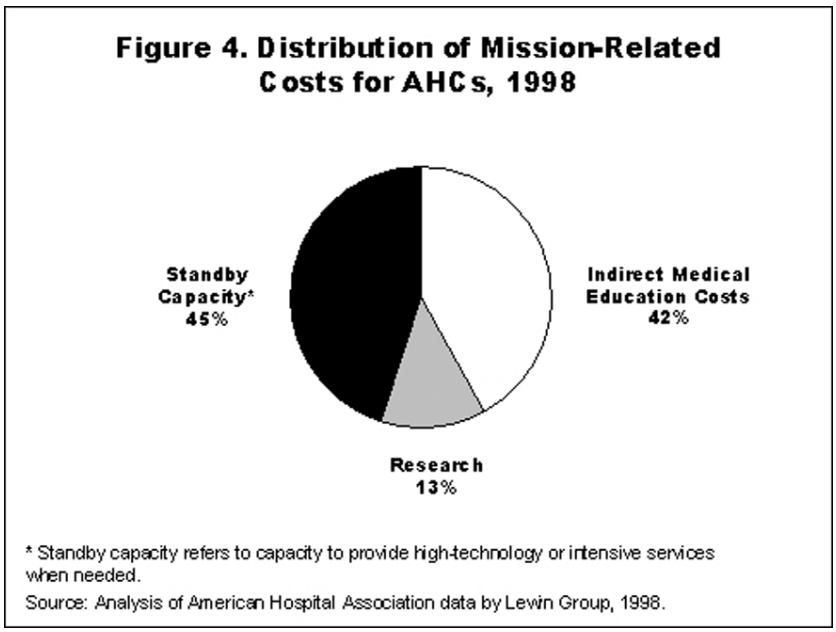
Figure 4. Distribution of Mission-Related Costs for AHCs, 1998
Standby Capacity* 45%
Indirect Medical Education Costs 42%
Research 13%
* Standby capacity refers to capacity to provide high-technology or intensive services when needed.
Source: Analysis of American Hospital Association data by Lewin Group, 1998.

Table 1. Total Clinical Costs of Mission-Related Activities by AHC Status, 2002* ($ billions)

	Direct Ed. Costs (DME)	Indirect Ed. Costs (IME)	Research Costs	Standby Capacity Costs	Total Costs	N**
AHCs	4.2	3.0	0.9	3.2	11.4	124
Other teaching hospitals	6.0	3.3	0.2	6.4	15.8	1015
All teaching hospitals	10.2	6.2	1.2	9.6	27.2	1139

*Costs have been estimated using the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System Hospital Input Price Index.

**N is the number of hospitals in the CMS Prospective Payment System Hospital Input Price Index.

Note: Numbers may not add up due to rounding.

Source: Lane Koenig et al., "Mission-Related Costs of Teaching Hospitals: Estimates of Graduate Medical Education, Clinical Research, and Stand-by Capacity" (Unpublished manuscript, November 2002).

Question from Chairman Amo Houghton to Mr. David Bernd

Question: In your written testimony, you stated that hospitals had been concerned about violating Federal regulations governing billing and collections if they discount charges to the uninsured. Can you provide to the Committee descriptions of Sentara's charity care policy before and after the February 19, 2004 letter by Secretary Thompson to Richard Davidson, the president of the American Hospital Association?

Answer: Sentara works diligently to qualify low income uninsured patients for public assistance through the Medicaid program or the Virginia State and Local Hospitalization program. For those patients that don't qualify for either of those programs, the Sentra charity program provides assistance for those uninsured patients whose family income falls below 200% of the Federal Poverty Level (FPL). The Sentara charity program has been in place for many years.

In my capacity as incoming chairman of the board for the American Hospital Association, I was involved in the development and approval, by the Board, of the Statement of Principles and Guidelines on Billing and Collections Practices (Guidelines) as well as AHA's efforts, in connection with successful implementation of the Guidelines, to secure needed regulatory clarifications from the Department of Health and Human Services (HHS).

In response to the Guidelines and in anticipation that HHS would, in fact, provide the necessary regulatory clarifications, in December 2003, Sentara implemented an additional program for uninsured patients whose family income exceeds 200% of the FPL. The uninsured discount program provides discounts to uninsured patients, on a sliding scale, based on family income level and the amount of hospital charges incurred. This program provides assistance to uninsured patients whose family income is between 200% and 500% of the FPL.

Question from Chairman Amo Houghton to Mr. Harold A. Cohen

Question: In your written testimony, you state that as of 1986 there had been no cases in Maryland of "patient dumping" because of the equitable funding of uncompensated care at Maryland hospitals. Is that still the case in Maryland?

Answer: As Dr. Cohen testified during his presentation, this original assertion was made in the mid-eighties by the Maryland Legal Aid Bureau during a legislative hearing in Annapolis, Maryland. To be consistent with the original testimony, we contacted Maryland Legal Aid to obtain a response to your question. According to Hannah Lieberman, Director of Advocacy, no cases of patient dumping in Maryland have been recorded. I am enclosing her written response with this letter for your review.

Thank you for the opportunity to provide you with further insight into Maryland's unique rate setting system.

[Submissions for the record follow:]

Statement of Reverend Michael D. Place, Catholic Health Association of the United States

As the U.S. House of Representatives Committee on Ways and Means Subcommittee on Oversight conducts the first in a series of hearings on tax exemption with a particular focus on hospital pricing practices, the Catholic Health Association of the United States (CHA) is pleased to provide this statement for the record. CHA is the national leadership organization representing the Catholic health care min-

istry. With more than 2,000 members, CHA is the nation's largest group of not-for-profit health care sponsors, systems, facilities, health plans, and related organizations from across the care continuum. CHA's members provide care to one in every six patients, either in an acute care or long-term care setting, in communities across the country. We have been caring for the nation's poor and disenfranchised for more than 275 years and remain committed to health care that works for everyone. Perhaps even more than the immediate issue of hospital pricing, the specific subject of this hearing, is the need to find a real and practical solution to providing health care coverage to nearly 44 million uninsured individuals. Finding a solution is critical to stabilizing our health care delivery system and remains CHA's number one priority.

The Catholic health care ministry has a long-standing commitment to ensuring that every patient has access to quality care, regardless of his or her ability to pay. The recent focus on the issues related to services provided to uninsured patients of limited means has been a solid reminder that as health care providers we must be ever-vigilant to the unintended consequences of the complex financial and regulatory environment in which we operate. Hospital pricing is a difficult and complex issue that has its roots in the prior cost-based reimbursement system. Hospital pricing is an intricate and detail-driven process that affects all aspects of the health care sector, not-for-profit as well as for-profit.

We fully support transparency in making financial assistance available and accessible for the uninsured and underinsured and in assuring quality care for the millions served by our ministry. As a ministry, we believe that all patients and their families deserve to be treated with dignity, respect, and compassion, not only when services are provided but also throughout the entire billing and collection process. To that end, members of the ministry have taken a thoughtful re-examination of their pertinent policies and procedures to ensure a greater degree of transparency. Many members of the Catholic health care ministry have publicized their efforts to review and amend their policies and remain committed to ensuring that uninsured individuals of limited means are not inadvertently disadvantaged by a fragmented and complex system. Additionally, the Catholic health ministry has long supported quality reporting initiatives, beginning with those related to our nation's long-term care facilities and now moving into our nation's hospitals. Patients have a right to the information necessary to make a reasoned and informed decision about where and from whom they receive their health care.

As tax-exempt organizations, the members of the Catholic health ministry are committed to fulfilling their obligations to their local communities. Catholic health care has its origins in a faith-based response to the health needs of vulnerable populations. Over a decade ago, the tax exempt status of our nation's not for profit hospitals was called into question and resulted in a robust dialogue about various issues related to exempt status. Partly as a result of those discussions, along with concerns of our sponsors and boards, the Catholic health ministry developed a process for planning and reporting community benefits, the *Social Accountability Budget.* Subsequently, with VHA, Inc, (a leader in community health improvement) and others, we developed a software accounting system for tracking community benefits and revised our document to what is now the nationally recognized *"Community Benefit Planning: A Resource for Nonprofit Social Accountability."* This is a community benefit planning resource to assist members of the ministry in examining their policies and ensuring that those policies encourage charitable behavior and responsiveness to communities.

Community benefit is a planned, managed, organized, and measured approach to a health care organization's participation in meeting defined, identified community health needs. It implies collaboration with a "community" to "benefit" its residents, particularly the poor, minorities, and other underserved groups. We encourage each of our facilities to develop a community benefit plan that includes a community needs assessment, services designed to respond to identified community needs (such as the needs of uninsured persons and activities to improve health in the community), and continual evaluation of the effectiveness and outcome of community benefit activities. The community benefit services provided include charity care, responding to Medicaid and public program shortfalls, education and research, and subsidized services (providing services where there is a community need but no business case for doing so), and outreach programs related to health improvement and prevention.

Throughout this process, members are encouraged to assess the particular needs of their communities, including addressing any disparities that may be evident. Outreach programs and community collaborations are encouraged to help meet the identified needs of the community and, in many cases, to step in where government programs and assistance may not be adequate to meet the needs of the community,

particularly those of the uninsured, the underinsured, and the poor elderly. As providers of health care services, major employers in our communities, and critical partners in community collaboration, we are proud of our long-standing commitment and continuing contributions to the communities we serve.

Notwithstanding the ministry's efforts at providing broad-reaching community benefits, there is a much larger issue that overshadows all of these issues and calls for immediate attention and real solution. Our nation faces an epidemic of uninsured individuals. Unlike many epidemics of the past, where every means necessary has been employed to find a cure or a solution, we, as a nation, seem paralyzed by partisan interests and bickering and continue to let this epidemic languish and worsen with time. The most recently available statistics note that nearly 44 million individuals go without any type of health care coverage. A recent study noted that one in three people in the United States under the age of 65 went without health insurance for all or part of the two year period 2002–2003. The issue of the uninsured is not an issue for government alone to solve, nor is it an issue that can be solved single-handedly by our nation's not-for-profit hospitals. But it remains an issue that cries out for action from all concerned Americans.

As members of the Catholic health ministry, we have our foundations in social justice teachings that acknowledge the human dignity of each person, have a special commitment to care for the poor and vulnerable, and call for responsible stewardship of resources. Furthermore, as a ministry we recognize health care as an essential social good rather than a commodity. Now is the time for a robust dialogue around a lasting solution for providing health care services for all. While there are tough moral, ethical, and policy questions to be debated, we must all—individuals at all levels of government, the private sector, the business community, the health care sector, the public policy thinkers, and the number crunchers—demonstrate "a willingness to take a step toward the middle," to leave our special interests behind and, once and for all, demonstrate a sense of collaboration and resolve that will allow us to surmount our differences and find a lasting and workable solution to providing affordable and accessible health care for all.

We are pleased to provide this statement to the Committee and to affirm the commitment of Catholic health care to providing quality care for all individuals, particularly the most vulnerable among us, and to strengthening local communities through a variety of services. It remains our most sincere hope that the issues raised by examining the problems of uninsured individuals will ultimately lead to a permanent and lasting solution for this national disgrace. On behalf of the Catholic health ministry, we thank the Committee for its interest in this matter.

Statement of Community Catalyst, Boston, Massachusetts

Community Catalyst appreciates the opportunity to submit comments to the members of the U.S. House of Representatives' Committee on Ways and Means' Subcommittee on Oversight in connection with its hearing on hospital pricing practices that was held on June 22, 2004. We applaud the Subcommittee for focusing attention on this very important issue.

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality affordable health care for all. It works with consumer health advocacy groups across the country that are fighting for health policy and system change at the local and state levels. It provides these groups with a range of support including policy and legal analysis, organizational development consultation, and community organizing assistance. In addition to our work with these groups on community-based health access issues, we work to build a national network of consumer organizations dedicated to securing universal access and health care justice.

We are submitting the attached *Patient Financial Assistance Principles* for inclusion in the hearing record. Since 1999 we have been working with consumer health advocacy groups that are concerned with access to hospital care for the uninsured. The centerpiece of this work was a report issued in October 2003 entitled *Not There When You Need It, the Search for Hospital Free Care.*[1] The report included findings from consumer surveys of more than 60 hospitals, conducted in 9 localities across the country. *The principal conclusion of the report was that information about financial assistance with hospital bills is* **not** readily available to consumers. Front-line hospital staff at the surveyed hospitals appeared to be almost universally unaware

[1] A copy of the report can be obtained at www.communitycatalyst.org.

of financial assistance policies, and they were also unable to redirect consumers/patients to hospital staff who might have that information. This was the case even where hospital leadership claimed such policies existed. Other findings were as follows:

That for low-income uninsured patients, a reduction in a hospital bill from "list charges" to an average discounted amount or "cost" is not sufficient to alleviate the health and financial consequences of being sick and lacking health insurance. The majority of the uninsured have incomes below 200% of the Federal Poverty Level, so a $15,000 hospital bill reduced by 50% to $7,500 is just as daunting a challenge to the uninsured person.

That hospital administrators are often unaware of the critical difference between notifying a patient at the outset of a hospitalization that they are eligible for free or discounted care and simply writing the account off at a subsequent time. Whereas the former means that the patient is never billed for the services, the latter simply means that the hospital does not expect to collect on a debt, even though collection action will continue and interest will continue to accrue.

That there are serious health and financial consequences for uninsured patients who are unable to obtain free or reduced cost hospital care. Many uninsured simply avoid seeking necessary care because they don't have the money to pay for it. And those who do seek it often find themselves saddled with debt and subject to aggressive collection actions that further undermine low-income family financial stability.

It was these findings, along with the extensive research that went into our report that led us to identify a set of imperatives that must be addressed in any hospital financial assistance policy. These imperatives are the basis for the enclosed principles.

Requiring hospitals to make free and reduced-cost hospital care more readily available is not a permanent solution to the problem of the rising number of uninsured in our country. Nor, for that matter, will the "health savings account" model of coverage with its high deductible alleviate the problem of impaired access and medical debt for either low-to-moderate income patients *or* the providers that treat them. The true solution lies in creating a program of comprehensive universal coverage. Until such a program exists, the burden of being uninsured will continue to fall primarily on the uninsured themselves. We can and should take action to distribute this burden more fairly. One step in this direction is to require hospitals to live up to their community responsibilities.

That said, we firmly believe that revoking the tax-exempt status of hospitals will not help them meet these crucial community responsibilities. Regardless of current concerns about some non-profit hospitals' operations and marketplace behavior, non-profit hospitals as a class provide the lion's share of free and reduced-price care. As such, they represent the ultimate safety net, not only for the 44 million uninsured but also for countless other financially strapped individuals and families who are facing escalating out-of-pocket costs for essential health services. The challenge for the Subcommittee and the rest of us is to ensure that tax-exempt status means something tangible.

Patient Financial Assistance Principles

Since 1999 Community Catalyst has been working with state and local consumer health advocates across the country who are concerned about access to hospital care for people with little or no insurance. Through this work, it has become abundantly clear that many hospital financial assistance policies are inadequate. The flaws include: a lack of clear and consistent eligibility standards, a failure to publicize the availability of financial help, and the use of harsh and inappropriate collection tactics. While a number of hospitals have been very responsive to consumer advocates' concerns, others have been slow to take action. In order to ensure people get the hospital care they need without incurring crushing debt, every hospital should adopt a financial assistance policy—whether voluntarily or through a statute or regulation—that includes, at a minimum, these 9 principles:

- **Eligibility.** Uninsured and underinsured individuals with incomes up to 200% of the Federal Poverty Level (FPL) should not be charged for hospital care. Individuals with incomes between 200–400% FPL should be eligible for financial assistance with their hospital bills. Financial assistance should also be available to individuals whose income exceeds 400% FPL but whose medical expenses have—or will—deplete individual or family income and resources to the point where the individual cannot pay for medically necessary services.
- **Amount of financial assistance.** Generally, the out-of-pocket contribution of a patient who is eligible for financial assistance should be limited so that it does not exceed a reasonable percentage of family income. A financial assistance pol-

icy that merely applies a discount to a hospital bill may not provide sufficient financial protection to an eligible individual. For example, it clearly is preferable—and more humane—to base the financial liability of an individual with an income of 300% FPL (i.e. $27,930 for a family of one) and a hospital bill of $50,000 on a reasonable percentage of his or her of income (e.g. 10%, or $2,793) rather than to have it set at a discount of 50%—or even 75%—of that bill.

- **Basis of financial liability.** Any amount owed by an individual who is eligible for financial assistance should be calculated using the hospital's cost of providing the care—or by using the lowest rate negotiated by any private third-party payer—rather than the hospital's substantially higher "list price." People who don't have insurance typically are charged the highest prices for hospital care because they do not have the benefit of an insurer or health plan negotiating on their behalf. As a result, they end up with the largest medical debt and are subject to the harshest collection actions, like wage garnishment, liens on personal property, and foreclosures on the family home.
- **Covered services.** Financial assistance should be available for any medically necessary hospital service and not just those services obtained on an emergency basis. This would include services delivered on an inpatient as well as an outpatient basis, and it would also include any medically necessary prescription drugs.
- **Notification of the availability of financial assistance.** Hospitals should broadcast the availability of financial assistance both inside their own institutions and to their broader communities. They should make sure that all staff who interact with patients and their families are trained to provide information on the hospital's financial assistance policies. Finally, hospitals should also ensure that the information is readily accessible to people who speak languages other than English.
- **Application process.** The financial assistance application form and process should be simple and "patient-friendly," and any income documentation requirements should not function as a barrier to receipt of financial assistance.
- **Payment plans.** Any payment plan shall be reasonable, taking into account the patient's—or his or her family's—income and other financial obligations, and limiting any interest charged on an outstanding balance to no more than 3% per year.
- **Role of hospital governing board.** Hospital governing boards should be required to review and approve all collection policies, including the policies of any collection agent or attorney, and any purchaser of a hospital account. Certain collection actions such as foreclosures, placement of liens, and wage garnishments should require specific board authorization before they are initiated, regardless of whether it is the hospital or any agent, attorney or purchaser of an overdue account that is initiating the action.
- **Reporting.** Hospitals should be required to report to a state agency—or otherwise publicize—the amount of patient financial assistance they provide on an annual basis, along with any other information that enables the public and policymakers to assess the hospital's application of its financial assistance policies. Financial assistance should be reported using hospital costs rather than standard hospital charges, and it should not include any costs associated with bad debt, so-called shortfalls from government programs such as Medicaid and Medicare, or contractual allowances provided to private third party payers.

Statement of Geoffrey C. Mitchell, Columbus, Ohio

Thank you for your willingness to investigate tax-exempt health care. As you know, we've reached a point where uninsured working people are actually being forced to subsidize billion dollar insurance companies. I think this is only the tip of the iceberg. The cost of health care continues to escalate while the quality may actually be decreasing. I believe this "value gap" is due to widespread looting of American health care.

Unfortunately the looting is not confined to for-profit enterprises. The leaders of non-profit enterprises too often emulate what they see in the for-profit world. ProvenaHospital is the obvious case in point but I'm sure there are others. Here is the story of the "non-profit" care provided by OhioHealth, the largest health system in Ohio. This is a tale of behind-the-scenes antics of hospital administrators who have forgotten the charitable mission of their organization.

There are four intertwining stories to be told, 1) administrator's secret drive to partner with and emulate for-profit corporate/criminal entities, 2) the securing of $200,000,000 in tax-subsidized bonds under false pretenses, 3) apparent private inurement at the highest levels of the organization, and 4) a full-fledged assault on indigent care by purchasing, then closing a hospital. Together, these stories bear directly upon the justification for granting tax-exempt status and the level of indigent and uninsured care provided by such "non-profit" hospitals.

Background

Riverside Methodist Hospital (RMH), the flagship of OhioHealth, is reportedly the 5th busiest hospital in America. Over the past decade, OhioHealth has capitalized upon the imbalance in Medicare reimbursement, focusing its attention on relatively lucrative cardiology services. This culminated in a recently completed $76 million "heart hospital." OhioHealth administrators call RMH the "Heart Institute of Ohio."

Not all patients benefited from OhioHealth's obsession with cardiology. Emergency department patients (ED) suffered greatly. For more than a decade, Riverside's express policy was to treat emergency patients in public hallways. This was a way to cut costs and increase profits. This policy negatively impacted patient care in many ways. One was that hallway medicine systematically discriminated against women. Men got EKGs done in the hallway, women did not.

In the late 1990's OhioHealth saw itself threatened by the expansion of for-profit hospitals, particularly Columbia/HCA. OhioHealth administrators undertook a three-pronged strategy. They instituted a vocal campaign to publicly denounce the "for-profit" hospitals. This continues today. At the same time OhioHealth was publicly denouncing the evils of corporate medicine, these same administrators cultivated a behind the scenes partnership with MedPartners, one of the most corrupt and/or inept companies ever known in U.S. health care. Finally, OhioHealth actually usurped Columbia/HCA and acquired the hospitals Columbia had pursued.

The Acquisition of the Two Doctors' Hospitals

Doctor's hospital was a two hospital system consisting of Doctors' West, a reasonably successful general hospital, and Doctor's North, which was losing money providing indigent care. Doctors West had enormous undeveloped potential as a referral hospital or portal of entry for cardiology patients on the west side of Columbus. Doctors' West is the closest hospital to the growing and affluent suburb known as Hilliard. OhioHealth and Columbia both yearned to possess Doctors' West.

OhioHealth succeeded in acquiring the two Doctor's Hospitals in 1998 but the $142 million price tag took a toll. At one point OhioHealth's bond rating was cut. By the fall, OhioHealth announced layoffs of 90 people. It was a difficult time.

Secret Contracting with For-Profit Corporate/Criminal Entities

The penny pinching required for the purchase of Doctors' meant RMH had to squeeze the emergency department (ED) even tighter. To accomplish this, OhioHealth contracted with MedPartners to run the RMH ED. At the time, MedPartners was the worst performing publicly traded company in America. Armed with this knowledge, RMH CEO David Blom was determined to contract with MedPartners anyway. Publicly, Blom was denouncing the evils of for-profit, Wall-Street groups but behind closed doors, he cut a secret deal with MedPartners.

When the RMH contract was negotiated, MedPartners' chairman was alleged criminal mastermind, Richard Scrushy. Scrushy has now been indicted on 85 criminal counts for massive fraud at his other company, HealthSouth. In order to make the deal work, Blom hired Clifford Findeiss to work as "hospital representative." At the time, Findeiss was being paid by MedPartners to negotiate and acquire hospital contracts on its behalf. Blom hired Findeiss to work for OhioHealth in its supposed "negotiations" with MedPartners. Findeiss had a direct reporting relationship to Richard Scrushy.

Thus, OhioHealth official Clifford Findeiss was actually being paid by MedPartners while he was "negotiating" with them. This arrangement had the appearance of a felony kickback. In addition to the alleged kickback there were other massive conflicts of interest. E.g., while negotiating with MedPartners on behalf of OhioHealth, Findeiss owned a million shares of MedPartners stock. This whole arrangement was the subject of a three-year investigation by multiple government agencies. Apparently, there was "not enough evidence to file criminal charges . . . at this time."

The RMH contract, negotiated by Findeiss, represented a trophy contract for MedPartners. The RMH contract was secured at a time when MedPartners was on the verge of bankruptcy. Scrushy had come from HealthSouth to assume the reins at MedPartners and rescue the company. As a result of his efforts, MedPartners was rescued. MedPartners was able to sell its emergency medicine business, Team

Health, to venture capitalists for $335,000,000. The venture capitalists boast that they make 40–50% annual returns on their health care investments.

Under the MedPartners contract, OhioHealth continued to squeeze the RMH ED and treat patients in the hallways. OhioHealth and MedPartners fired and defamed doctors who opposed their methods or spoke out about the declining quality of care. Quality was declining because fraud undermines the quality of care. There were many examples of poor quality care under the umbrella of MedPartners. At RMH, a fifteen year-old girl was paralyzed at the hands of the local MedPartners quality expert. Findeiss' jail staffing company, EMSA, left a trail of wrongful death suits across the country. In New York, EMSA hired a convicted killer to treat patients.

OhioHealth continued to mandate the practice of hallway medicine in the RMH ED. Then, in 1999, the overcrowded RMH ED was featured on CBS's *60 Minutes* (No Vacancy). *60 Minutes* had over 4,000 hospitals to choose from. They chose RMH as the lead for this story. A five year-old boy had been turned away from the RMH ED because "every bed was filled." He died en route to another hospital. As a result of a lawsuit and the feature story on *60 Minute* s, OhioHealth eventually reversed course. In December of 1999, OhioHealth announced plans to expand the RMH ED. The new ED was incorporated into the ongoing plans for the new cardiology tower.

False Pretenses in $200,000,000 Bond Finance Deal

In the fall of 2000, OhioHealth sought FranklinCounty's approval of $200,000,000 in tax-subsidized bonds. They wanted this money to build cardiology towers at RMH and Doctor's West. The County held the requisite TEFRA hearing and invited me to attend. I understand that the federal government mandates TEFRA hearings in an attempt to guarantee fairness and fiscal responsibility in the funding of non-profit organizations. Believing I had just the sort of inside information that a TEFRA hearing is designed to uncover, I offered testimony to the Hospital Commission.

I testified with regard to what I believed to be fraudulent contracting between OhioHealth and MedPartners. Three years later, more than a dozen HealthSouth executives and officers were indicted/convicted and/or fired for their role in fraud with Richard Scrushy. At least five of those individuals including Scrushy himself, were at MedPartners when the RMH contract was negotiated.

OhioHealth attorney Penny Proctor attempted to contradict my testimony. I testified that OhioHealth had contracted with MedPartners and maintained a contract with MedPartners successor, Team Health. Ms. Proctor stated categorically, "[t]here is no contract with Team Health." Her testimony may be found in the public record. Seen in the most favorable light, Ms. Proctor is like child making a promise with her fingers crossed behind her back. However, as an attorney and with $200,000,000 at stake, this is no trivial act.

It is an undisputed fact that OhioHealth contracted with Mid-Ohio Emergency Services (MOES). MOES is a MedPartners/Team Health subsidiary completely controlled by MedPartners/Team Health. Secondly, is Ms. Proctor really claiming that this 501(c)3 charity sent $60,000,000 to Team Health without a contract? This is a gross breach of fiduciary duty. Thirdly, the continued absence of a contract with Team Health would now be prohibited under HIPPA law. OhioHealth has sent about a half a million confidential patient records to Team Health.

Despite whatever convoluted technical sense in which her testimony might contain some grain of truth, Ms. Proctor had one goal, to deceive the Hospital Commission. Ms. Proctor sought to distance OhioHealth from MedPartners, to publicly deny OhioHealth's affiliation with MedPartners. Ms. Proctor's role was, like the old Mission Impossible cliché, to "disavow any knowledge" of MedPartners.

There are two more ethical, and perhaps legal, problems with her claim. One, her public claim appears diametrically opposed to the testimony OhioHealth officials offered to federal investigators behind closed doors. There, it appears they claimed that they fully intended to contract with MedPartners, that they knew that Findeiss worked for both MedPartners and OhioHealth at the same time. Which version is true, the one offered to federal investigators or the one offered to the Hospital Commission? Which version is false?

The most sinister aspect of Ms. Proctor's false testimony is that it was made with the goal of obtaining $200,000,000. Ms. Proctor knew or should have known OhioHealth had a contract(s) with MedPartners/Team Health and/or its subsidiaries. Ms. Proctor misrepresented these facts to the Hospital Commission. Does this amount to false pretenses in non-profit hospital financing?

The Subsequent Closure of Doctors' Hospital North

At one point Columbia/HCA sought to purchase Doctors' Hospital. They signed a letter of intent in March of 1997. Like OhioHealth, Columbia saw the lucrative cardiology potential of Doctors' West as the prize. The indigent care at Doctors' North

was a burden. The deal required the approval of the Ohio Attorney General. OhioHealth CEO, William Wilkins, vigorously opposed Columbia's efforts and filed a written response. The accusation was always that if the deal was allowed to proceed, Columbia would close Doctors' North. Another hospital system, Mt.Carmel had lost the deal for exactly that reason.

In late 1996, the Ohio AG began to expand the AG's oversight role under the Charitable Trust Act. Wilkins may have had some role in this. He appeared as a panelist at a symposium organized by the AG in April, 1997. The Doctors'/Columbia deal soon fell through. OhioHealth then reached an agreement to purchase Doctors' Hospitals in August. The deal was approved by the AG in October. OhioHealth was awarded the contract because they promised Doctors' CEO that they would not close Doctor's North. It appears that the Ohio AG understood this promise as well. This appears to have been a condition of the Attorney General's approval. The Ohio AG's office said that their approval of the sale to OhioHealth, "reduces our concerns over potential hospital closings." OhioHealth repeated this promise to the community. They promised not to close Doctor's North.

OhioHealth's supposed plan to rescue Doctors' North relied upon cardiology services, specifically a heart surgery program. This was rather silly because it meant competing with the OhioStateUniversityMedicalCenter which was just a few blocks away. Predictably, the heart surgery program failed and Doctors' North died a slow death. It closed inpatient services in 2001.

The non-profit "charity" known as OhioHealth made a "profit" of $86 million after it closed the door to the indigent patients at Doctors' North.

Private Inurement to OhioHealth CEO & CFO

Investigation of the OhioHealth/MedPartners connection uncovered evidence suggesting private inurement to top OhioHealth executives. In 1996 CEO William Wilkins and CFO Dennis Freudeman filed to incorporate the Upper ArlingtonSurgeryCenter aka the RiversideOutpatientSurgeryCenter. There are several indications that the ownership of this surgery center was structured differently than all other OhioHealth surgery centers. Evidence indicates that the RiversideSurgeryCenter is a privately held, for-profit entity.

The RiversideSurgeryCenter holds itself out to be part of the non-profit, RiversideHospital. The Center uses Riverside's name and logo. In newspaper articles and its annual reports OhioHealth indicates that the RiversideSurgeryCenter is part of (non-profit) OhioHealth.

Publicly available state records indicate that Wilkins and Freudeman still own the SurgeryCenter long after they left OhioHealth. The problem is that this is not a separate, arm's length business entity owned by Wilkins and Freudeman. This is not Bill & Denny's SurgeryCenter. Wilkins and Freudeman were able to acquire their ownership stake by virtue of the fact that they were officers of the non-profit charity, OhioHealth. Wilkins' and Freudeman's ownership stake is almost certain to be profitable. The RiversideSurgeryCenter is strategically located in one of the most affluent sections of town.

When I sought information about this possible private inurement under the FOIA, I was told that the SurgeryCenter is a for profit venture thus no disclosure is required. Charitable 501(c)3 organizations are required by law to accurately and publicly disclose the income of their executives. Private inurement is a basis for revoking an organizations 501(c)3 status. OhioHealth did not report any income from the surgery center to William Wilkins and Dennis Freudeman. Wilkins and Freudeman were respectively the CEO and CFO of OhioHealth. If they had additional undisclosed income as a result of their positions, I understand this would be a violation of law. Since they refuse to disclose the income from the SurgeryCenter, it appears this may be the case. It appears that Wilkins, Freudeman and OhioHealth are concealing private inurement.

Were there other examples of private inurement at OhioHealth? We now know that Richard Scrushy's other company, HealthSouth, paid bribes to acquire hospital contracts. Also, in a recent California court case, several doctors alleged that MedPartners' successor, Team Health offered kickbacks for assistance in acquiring the hospital's ED contract. This suggests the possibility of other kickbacks or private inurement at OhioHealth.

Conclusion

Certain hospital administrators and corporate executives abuse and exploit the 501(c)3, non-profit hospital system. It's not known how much private inurement may have passed to Wilkins and Freudeman nor is it known exactly how Blom and/or Wilkins and others may have profited from their relationship with Scrushy's MedPartners.

It is known that OhioHealth CEO Dave Blom seemed infatuated with MedPartners and welcomed them with open arms. It is also known that Richard Scrushy and Clifford Findeiss made or recouped tens of millions of dollars in their rescue of MedPartners. That rescue coincided with the secretive and I believe, fraudulent contract with OhioHealth. Scrushy's successors, Team Health, its executives and the venture capitalists make about $150 million per year from our nation's emergency care system. I think the evidence shows little if any value added by these expenditures. In fact, I believe it can be shown that the quality of care actually declines as a result.

The solution is not to abandon the non-profit system. The solution is to enforce laws already on the books, laws designed to prevent kickbacks and private inurement. Where federal laws are unclear and unenforceable, Congress should work with prosecutors to clarify statutory language so the law may fulfil its intend purpose.

We must not abandon the non-profit hospital system. To do so would be to relinquish health care to the Richard Scrushys of the world. We can't depend upon them to provide compassionate, high-quality health care.

If this is the kind of information you seek, please advise and I will gather my evidence in support of my allegations. Thank you.

Statement of Pat Palmer and Nora Johnson, Caldwell, West Virginia

Hospitals assert that they bill all payers, including CMS, uniformly. What is not often said, particularly to the under-insured or the uninsured, is that all payers are not expected to reimburse uniformly for the billed charges. Typically, CMS reimburses the lowest amount, major insurers the next lowest amount, and the working poor and uninsured pay the highest rate. It is our understanding that, when referring to a facility's Cost-to-Charge ratio, many hospitals bill uninsured patients 3 to 4 times the amount accepted as payment-in-full from insurance companies. A careful review of individual items and services contained in itemized statements will demonstrate mark-ups in excess of 4000%, and a major facility routinely charges for a solution that is marked up 367 times cost.

The area of unconscionable mark ups, is merely part of the problem confronting our nation, the easiest to attack, but not the easiest to rectify. *An effort to remedy overcharges by exacting an agreement from hospitals to apply a discount to uninsured, whether it is 40% or 80%, is hopelessly naïve, totally ineffectual, and contraindicated by the billing examples we can provide for the Committee.* Major healthcare systems are offering such discounts for the purposes of simultaneously appeasing lawmakers, generating good public relations, and emphatically protecting profits.

In fact, a proffered discount is meaningless when counter-balanced by rampant billing violations. The federal government has mandated that facilities bill according to accepted guidelines. The government considers violations of these billing guidelines fraudulent and/or abusive. If CMS defines a billing pattern as fraudulent and abusive when submitted to the federal government for reimbursement, then why is it legal to foist the same billing pattern upon the public? Why are courts forcing private payers and the uninsured to pay facilities for hospital bills defined as fraudulent and abusive by CMS and the OIG? Are these guidelines applicable to payers other than the government?

The Health Insurance Portability and Accountability Act of 1996 (HR 3103) or HIPAA Section 241

"With the passage of HR 3103 on August 21, 1996, *Congress declared war on all health care fraud and abuse and applied this provision to all payers.* Health care fraud is now a "federal health care offense" with the full arsenal of federal law enforcement agencies available to find and punish violators. Fines are stiffer than in the past and transgressors face possible prison sentences. For purposes of this law, a health care benefit program is defined as:

"any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual and includes any individual or entity who is providing a medical benefit, item or service for which payment is made under the plan or contract."

Source: Complete Guide to Part B billing and Compliance, February 2002Page Compliance-5 Published by Ingenix.

If, this is true, then why hasn't the government acted upon the providers and facilities that flagrantly violate billing guidelines?

1. The OIG has, to some extent, but its results rarely redress private payers.
2. CMS reimburses electronically via HCFA forms and UB–9X's. The charges are grouped, and reimbursement is made according to the applicable reimbursement system, (DRG's, APC's, etc.) An itemized statement is usually not germane to the DRG/APC reimbursement system.
3. Billing violations are more easily identifiable when a line-by-line examination of the itemized bill is performed. This is rarely done by payers, and few have the expertise.
4. Most auditors are not educated in the area of billing compliance guidelines as established by the federal government. A hospital or insurance company audit examines items/services ordered and documented in the medical record, and merely verify the quantities of such as reported on the bill.
5. Facilities excel in creating cryptic, non-informational masterpieces, euphemistically referred to as 'itemized bills'. The less sense a payer can make of the bill, the more cents the provider can make with it.

The fact is that the overwhelming majority of hospital bills generate charges from line items that are fraudulent and abusive according to Federal Billing Guidelines, and coding guidelines as set forth in the Current Procedural Terminology copyrighted by the American Medical Association. *Excessively billed items and services include:*

- Routine supply charges that have been calculated into the cost of the room or service, and are duplicated on most bills with individual charges attached;
- Equipment charges for non-billable equipment;
- Unbundled procedure coded charges that emanate from hospital chargemasters' in direct violation of the Correct Coding Initiative established by the National Correct Coding Council developed for CMS Bureau of Program Operations.

Another trend and very troubling area is the emergence and charges for disposable operating equipment. Equipment used multiple times and for multiple patients is considered as part of the accommodation or facility charge. One of the criteria defining ancillary supplies is that they are either not re-useable (hence disposable) or represent a cost for each preparation. This definition has given life to an entire mega billion dollar industry of "disposable surgical equipment". The result is that hospitals have discovered a new revenue center and now bill for and use disposable equipment with abandon and capitalize on enormous mark-ups as well. The red flags wave when the cost of 'disposable equipment' exceeds the cost of permanent reusable equipment.

Hospital drug billing: many providers make a majority of profit on drug billing. Aside from the obvious mark-ups, it is common to see line-item charges for a vile of medication containing 5 mg billed for each use, when in fact the patient was prescribed 1mg per dose, 2 times daily. A phone call to the hospital pharmacy usually substantiates that 1 mg vials are in stock. If 1mg vials are available in the hospital pharmacy, or available for order from a wholesaler, hospitals have no justification for daily charges of the 5mg vial repeatedly for weeks. Billing for items or services not rendered is #1 on the OIG's risk areas for fraud and abuse. This issue is separate from situations requiring use of a drug that cannot be used again, or drugs that have a limited shelf-life once opened.

Hospitals bill whatever they want. They refuse to be accountable for, items fraudulently and abusively billed, errors billed, and grossly flagrant and unconscionable mark-ups.

There is NOT ONE entity in the United States of America that will enforce federal compliance billing guidelines as they relate to private sector patients.

One quandary faced by most patients is: do I take my finite dollars and fight the hospital bill by hiring an attorney? Or do I take my finite dollars, save my credit rating and good name, and just pay the hospital or collection agency? The answer is as obvious as the choice is narrow.

The concept of making hospital prices more transparent via publication of charges designed to assist informed consumer choices will meet with abject failure. That hospital will not tell consumers that they will be charged an extra:

- $57 for a FRED. (Fog Reduction Elimination Device—a 2X2 gauze used to wipe moisture from lenses in the operating room——not a billable item);
- $200 for a bag of IV solution that costs the hospital about 25 cents;
- $985 pair of scissors which is not a billable item;

- $1,028 for a contrast solution that CMS deems not chargeable as it is included in the cost of the procedure;
- $11 for a mucous recovery system—a box of tissues
- $350 for an IV start kit that is un-billable in the O/R and costs less than $2.
- Thousands of dollars per day for Nursing Services that CMS mandates as incorporated into the daily room charge and is not separately billable.

Are the hospitals going to inform patients of these charges before they appear on the bill? Look at the dollars in their off-shore accounts, the CEO & CFO salaries, then answer.

Report Summation:

The purpose of this report is to expose a few of the unscrupulous billing methods and price gouging, regularly used by hospitals nationwide. These examples represent a majority of hospital bills that we have reviewed, ranging from the most prestigious institutions in the country to religious affiliated hospitals, and corporately owned facilities.

The examples provided represent a few of an infinite number of methodologies that hospitals can employ to feed the bottom line. There are hidden charges in most hospital bills, and these hidden items can appear simultaneously, in several different places on the bill, with different charges and descriptions that illegally inflate the billed total.

Recommendations:

1. The enforcement of HR 3103, Section 241 of HIPAA, is imperative. If billing is truly uniform, then the standards and definitions for fraudulent and abusive billing should be enforced and extended to all payers from all sectors.
2. Patients should have access to an itemized hospital bill—for free and without encountering hostility from hospitals staffs. There are facilities in Nashville that charge $13.00 for an itemized bill that CMS has mandated as a right to their beneficiaries without charge.
3. Patients should also have the right to a UB–92, whether or not they are insured. The information on the UB–92 is supplemental and helpful when analyzing the itemized statement, and the provision of such would not pose a significant additional burden on the hospital.
4. Regarding hospital cost reports submitted annually to CMS: are the inflated or CMS non-reportable charges that are billed to other payers, calculated into the cost report? Do these charges impact CMS or the facility cost-to charge ratio for the following year?
5. How much is too much? What constitutes a 'fair and reasonable' price? Can we afford to suspend businesses rights to profit? Hospitals are big business. A new 'profit makes right' morality has emerged in the last three decades, and its heroes are being consecrated. They are the captains of industry who have amassed great wealth for themselves and their businesses. We hail them and then jail them. This bottom-line morality/mentality has pervaded the once held sacrosanct hospital, and the nation is footing the bill.

A great man, a 'captain' with a conscience, told us that DRG plus 26% would be a fair and equitable reimbursement for hospitals, juries are in agreement, and so are we.

Statement of VHA, Inc.

Not-for-profit health care organizations are the backbone of the nation's health care system, representing most of the nation's largest and smallest hospitals, and providing the large majority of care to the uninsured and underinsured patient population. Many of these institutions are delivering on their promise of community service every day, while also establishing clinical standards that make America's health care system the most advanced and sophisticated in the world. These hospitals are also investing in specialized programs and technologies that improve their business operations while actually reducing costs.

However, a number of socioeconomic, political and cultural issues have converged in recent years to create a significant threat to our health care system. Not-for-profit hospitals are struggling to balance competing priorities and pressures. Hospitals are faced with limited reimbursement from both private insurers and the government, the imperative to acquire breakthrough clinical and operational technologies, as well as the need to expend resources to attract and maintain a strong workforce. Fur-

thermore, the number of uninsured and underinsured individuals in the United States is increasing, placing an additional strain on the nation's not-for-profit health care providers. Caught between these realities, not-for-profit hospitals and affiliated physicians endeavor to remain true to their historic missions to provide charity care and other community benefits, while remaining financially viable.

Public attention has turned to examples of instances when hospitals have acted aggressively to collect money from uninsured or underinsured persons, yet little attention is paid to the community benefits that not-for-profit hospitals consistently provide.

As the nation's largest alliance of not-for-profit health care organizations, VHA Inc. believes hospitals and policy makers should work together to better address the issue of caring for the uninsured and underinsured. Hospitals must offer transparency regarding the charges associated with providing care as well as assure high-quality care for the uninsured and underinsured. We urge Congress to work toward bipartisan, achievable solutions to address the health care coverage needs of this population.

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