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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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PRICE TRANSPARENCY

TUESDAY, JULY 18, 2006

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

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

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 11, 2006
HL–17

CONTACT: (202) 225–3943

Johnson Announces Hearing on Price Transparency

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on price transparency in the health care sector. **The hearing will take place on Tuesday, July 18, 2006, 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 the invited witnesses only. Witnesses will include representatives from the insurance industry, the health care provider community, and the academic community. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

This hearing will focus on efforts to develop greater price transparency in the health care sector and follows on a prior Subcommittee hearing in December 2005 in Milwaukee, Wisconsin. That hearing focused on a report by the U.S. Government Accountability Office (GAO) on price variations for health services within the Federal Employees Health Benefits Program. The GAO found significant price differences for hospital inpatient and physician services in different areas around the country, and that areas with the least competition among health care providers had higher prices than areas with more competition.

Congress needs to better understand the importance of increasing price transparency, its potential impact on slowing spending growth, and efforts undertaken to accomplish this goal. Health care is the only major sector of our economy where consumers and providers have virtually no useful information on the true costs of medical goods and services. Greater health care price transparency has the potential to increase competition and create pressures to contain or reduce health care costs. Some private health insurers and health care providers have recognized the importance of providing greater market-based information to their customers and the public, both on health care price and quality.

In announcing the hearing, Chairman Johnson stated, "Rising health care costs and greater transparency are two of the most important issues confronting Congress and the nation. Greater competition among health care plans and providers is an essential element in reducing costs. One tool that can promote competition involves greater price transparency for health care services, which will serve to provide valuable consumer information. As Congress struggles with increasing costs and demands in all of our health care programs, especially Medicare premium growth, it is essential that Congress continue to explore root causes and find ways to slow the growth in Medicare and overall health care spending."

FOCUS OF THE HEARING:

The hearing will focus on initiatives to develop greater price transparency in the health care sector and the impact and benefits of price transparency, including the potential for increased competition, lower costs, and lower spending growth.

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 "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). 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, August 1, 2006. **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.

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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 JOHNSON OF CONNECTICUT. This is an important hearing, and I appreciate your attendance and participation.

It is always hard to move into a future that is unlike your past, and we have an entire health care system built on insurance coverage and not built on either price or consumer choice. So, today's hearing does focus on the development of greater price trans-

parency which I see as simply a natural component of any modern health care system in the future.

We did have a Subcommittee hearing in December in Wisconsin to review the Government Accountability Office (GAO) report and geographic price variations in the Federal Employees Health Benefits program and the effects of competition on prices in the Federal Employees Health Benefits program.

One of the most interesting pieces of information to come out of that hearing was information presented by Richard Blomquist of Blomquist Benefits Consulting in Milwaukee. He had formerly run a health care plan, so he was familiar with what prices really are charged to insurance companies.

In the course of his testimony, he pointed out that one of the byproducts of this evolution away from prices was a significant difference in the cost of similar services at different hospitals. A $2,000 service in one hospital can cost $6,000 in another. A normal delivery ranged in the Milwaukee area from $4,681 at Waukesha Memorial to $9,045 in Aurora. A cardiac catheterization ranged from $60,000 at Waukesha Memorial to $146,000 at St. Joseph's. So, the examples that he gave and his testimony overall just reminded us how very important it is for people, individuals, plans, groups, to have access to information about what plans are charging customers.

I have one hospital Chief Executive Officer (CEO) that says, "I am tired of being the only one in the room that doesn't know what the other hospitals in the region are charging for a service and being told by the particular hospital I am negotiating with that they can get this service cheaper from everyone else, knowing full well that I run a very efficient outfit and I can't provide it cheaper." So, the negotiations that go on now in the system are not honest negotiations, because you don't know who really is charging what for what.

Congress is interested in providing consumers with greater health care information and has begun taking steps to do so. For example, the Medicare Modernization Act of 2003 (MMA) (P.L. 108–173) contained a provision that tied a hospital's annual Medicare update to the reporting of quality information, has led to the development of the Hospital Compare Web site, which publicly reports the collected data on the reported hospital quality measures.

The Deficit Reduction Act (P.L. 109–171) passed just last year expanded this quality reporting system and is ultimately expected to result in the collection of more sophisticated and detailed hospital data. Other provider groups would similarly be expected to develop and report similar health care information.

Since price is not the only thing to be considered, quality is to be considered; and there are lots of other things—quality of communication with physicians and quality of services and so on. So, this is only one piece, never to be mistaken for the whole.

We have heard much discussion about price transparency and what it can and can not provide; and we need to get a better grasp of how we talk to each other about providers, what it means when we talk to each other about price and how consumers and other buyers can have better understanding about price.

Medicare recently disclosed payment information for certain procedures. Although this is a good first step, in my mind much of that information was already available. Many recognized the limited value of such information because the Government prices do represent a mandated price system with lots of adjustments, some of which are accurate and some of which are inaccurate. Various efforts are under way in the private sector and private insurance and provider sectors that are intended to help increase and provide the information available to health care consumers, and we will hear more about those efforts today.

These voluntary efforts have been critical, but, to date, they have not resulted in a comprehensive system that provides adequate price and valuable information to the consumers of health care, many of whom are uninsured or those who take the responsibility to shoulder their own costs.

I would also like to point out in my opening comments that the Health Care Financial Management Association has issued an interesting report on this issue of transparency, and their report does demonstrate how many systems will have to change to achieve that outcome we are looking for which is some honest knowledge on the part of those who seek it of the costs of medical care.

Today, our experts will provide us with a review of price transparency and health care. We will hear testimony from academia, the hospital sectors and the insurance sector. They will provide information on private-sector efforts to increase the amount of meaningful information to consumers, and suggestions for what can be done to improve the system.

Mr. Stark, would you comment, please.

Mr. STARK. Thank you.

The topic today is, in an academic sense, kind of interesting, but I think we have many more important issues we should be considering.

Now the primary focus of this hearing is on hospitals, and that to me makes—I want to say the least sense. In other words, most hospital care isn't discretionary. You want to talk about should we be focusing on transparency on drug prices, physician fees, that makes some sense, but relatively few people admitted to hospitals—there are relatively few. Each year, 40 or 50 percent of them come into the emergency room. They don't have any choice. A cardiologist informed me recently that 70 percent of his patients are either emergencies or urgent cases in which the patient has little or no choice.

Most people don't actually have a choice of hospitals anyway. In other words, they have to go to the hospital that is in their insurer's network or at which their physician has privileges or else they have to change doctors.

Hospital costs are so high that most patients would go through their deductible, even a high-deductible plan, with one admission and might even hop over their catastrophic tap. So, it doesn't make any difference. You go to the lowest-priced hospital in town and you are still out of pocket a lot of money.

Now, having said that, I would think as between insurance plans and providers and large companies this information would be useful in helping them reduce the costs of their insurance programs,

but I want to urge the Committee not to think of this as doing anything for the consumers.

I had fun with Mr. Evans last time he was here, and I spent almost an hour online last night, delightful company, Clarian Health Partners, and I couldn't get the price of a mammogram or a colonoscopy. Mr. Evans, last time he was here, didn't know the price of a colonoscopy, but I'm sure he knows that now. I am going to ask about mammograms today.

I got a long issue about my responsibility to pay my bills to Clarian, two pages of that; and, in mammograms, I was told how old I had to be and where I could go and what the risks were. No money. I put up here it says "search." I said, cost of mammogram. I couldn't get an answer. I said, charges for mammogram. I couldn't get an answer. Now he is going to hear them telling me I should know that and I can't get that out of his highly rated hospitals. I shouldn't have had a mammogram anyway.

What I am suggesting is that if I were Blue Cross or Aetna, I think this would be important, but I think that we should focus on those areas in which the consumer could reasonably be expected

The last thing is, if we want the consumer to take the lowest cost, we may be disadvantaging them in quality because they don't always equal. So, I hope we can focus on the importance of overall costs but not think that just to say, gee, if the consumer knows what the price list is, he or she will make better choices and save money. I think that is more than we can ask. Those of us who more fortunate than us, who have not had a spouse to go to medical school, how is that

Chairman JOHNSON OF CONNECTICUT. I thank the gentleman. Both of your comments are certainly valid.

As we move forward on this, I think we do have to keep in mind that the plans have an honest level playingfield to compete on is important to overall costs and will matter; and, furthermore, private-sector costs and public-sector costs I believe need to be more public to hold the public sector accountable for the level of under reimbursing that in many areas is perpetrating the system. So, I am not bound into where this is taking us, but I do think it is important knowledge that we have to know, and I appreciate the significance of the issues that you raise.

Let us start today with Dr. Herzlinger. Welcome and thank you for being here.

Ms. HERZLINGER. Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. I should mention for all of you that your entire testimony will be included in the record. Your opening statement time is 5 minutes, and then we will go to questions.

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

Ms. HERZLINGER. Madam Chairperson, Representative Stark, gentlemen, thank you for inviting me to testify.

I am a professor at the Harvard Business School where I separately teach accounting and health care.

Currently, many consumers here are injured by the absence of price transparency in health care. Although there is substantial variation in hospital and physician prices, as the GAO discovered at the behest of this Subcommittee, those who pay for their own health care expenses lack the price information they need. The consumers injured include the more than 40 million people who are uninsured, most of whom are poor. Hospitals have raised their charges substantially for the prices for self-paying consumers. While the number of hospitalizations by the uninsured remain the same, hospital charges to them increased by 55 percent since 2000. Small wonder that medical debt is the second leading cause of personal bankruptcy. The growth in high-deductible health insurance policies further increases the need for price information.

Self-payers need information on the prices that others paid, not on charges. Even those who are fully insured are injured by the absence of price transparency and the improvement and efficiency that transparency typically causes. Employees are increasingly paid in health insurance benefits rather than wages.

Now what happens when people have access to good information and freedom to choose health care plans and providers? They make good decisions. The Twin Cities employer coalition, the Buyers Health Care Action Group, helped to cause a nearly 20 percent drop in high-cost, low-satisfaction plans, each composed of a unique set of providers and a 50-percent increase in low-cost, high-satisfaction plans when it gave price and satisfaction data to consumers.

Similarly, Aetna showed reports that have demonstrated cost-effective changes in behavior among those enrolled in high-deductible plans, decreased utilization of ERs and over-the-counter medications and increased compliance with drugs for chronic diseases and yearly examinations.

When McKinsey asked enrollees about these changes in behavior, they said, "If I catch the issue early, I will save in the long run." In other words, when people have information and they have control, they change their behavior.

Two ingredients are crucial to such changes. One is information and the second is an assertive group of people. These are the marginal consumers that you learned about in your dreary Economics 101 classes who equilibrate the market.

Do marginal assertive consumers subsist in health care? A 2005 report found that 95 million people use the Internet for health care information, 60 million of them daily. More than 70 percent of them want on-line evaluations of physicians, and when they obtain this information they use it. Consumers are also willing to change hospitals in response to information.

So, how can Congress help to make health care more transparent? In some other sectors of the economy, transparency did not occur until the Government required it. For example, accounting was discovered in the middle of the 15th century but transparency in the securities market did not occur until some 500 years later.

Many credit the transformation to Franklin Delano Roosevelt and his visionary creation of the Securities and Exchange Commission (SEC) which had the power to regulate information. The SEC is not perfect, but it serves as a worldwide model of how Government can help to achieve transparency.

Thank you so much.

Chairman JOHNSON OF CONNECTICUT. Thank you, Dr. Herzlinger.

[The prepared statement of Ms. Herzlinger follows:]

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

Summary

Every day consumers use information to decrease costs, improve quality, and increase the range of choices even for complex financial services and high-tech products. They could achieve the same results in health care if price and other information about specific providers were more widely available. The SEC, which transformed the transparency of the world-class U.S. capital markets, provides a good model of how to make it happen. But the transformation will not be an easy one. Just as FDR bucked substantial business interests to create the SEC, the current government faces powerful, well-financed opposition by providers to transparency.

How the Absence of Price Transparency in Health Care Hurts Consumers

Currently, many consumers are injured by the absence of price transparency in health care. Although there is substantial variation in hospital and physician prices, within geographic regions,[1] those who pay for their own health care expenses lack the price information they need to obtain the best value for the money.

The consumers injured by the absence of information include the more than 40 million uninsured. Hospitals have raised their charges—their prices for self-paying customers—substantially: in 2003, as the number of hospitalizations by the uninsured remained the same, hospital charges to them increased by 55%, since 2000.[2] While denying wrongdoing, Catholic Healthcare West agreed to pay estimated hundreds of million of dollars to settle a lawsuit about overcharges to the uninsured.[3] Small wonder that medical debt is the second-leading cause of personal bankruptcy. The growth in high deductible health insurance policies further increases the need for price information.

Even those who are fully insured are injured by the absence of price transparency and the improvement in efficiency that transparency typically causes. Insured employees are increasingly paid in health insurance benefits, rather than wages, because the growth in health care costs outstrips that of the economy. For example, "In 2003, a major union group in the Milwaukee area needed additional money to cover the cost of the health benefits. The trustees of the benefit plan were forced to take 50 cents an hour out of . . . employee pay to cover those costs. In June, a $1.50 an hour raise was entirely dedicated to the health benefits. With that amount, each employee saw over $4,000 a year go to the health benefits instead of the pay envelope. These employees are purchasing fewer clothes, smaller cars and less expensive homes. . . ."[4]

Is Health Care Information Good for Your Health?

Consumers who have access to good information and the freedom to choose health care plans and providers, have optimized in classic Economics 101 fashion. For example, the price and satisfaction disclosure of the Twin Cities' employer coalition, the Buyers Health Care Action Group, helped to cause a nearly 20% drop in high-cost/low-satisfaction plans, each composed of a unique set of providers, and a 50% increase in low-cost/high-satisfaction plans.[5] Even in 2006, early in the program's history, Medicare Part D has already illustrated the power of price transparency: enrollees have chosen plans with premiums of $24, rather than the $37 initially expected.[6]

But, even in the absence of consumer choice and control, the compilation and dissemination of information exerts powerful effects on suppliers.[7] In the accounting literature, this phenomenon is well-known as the *audit effect:*[8] firms improve their management in anticipation of an accounting audit. In health care, many of the reviews of the impact of published data on physicians, hospitals, and insurers have concluded that they resulted in improved outcomes and/or processes.[9]

New York State's experience illustrates the results when government requires meaningful health care information. Three years after New York State's commissioner of public health requested data about the risk-adjusted death rates of open-heart surgeries performed by different surgeons and hospitals, the state achieved the lowest risk-adjusted mortality rates in the country.[10] Physicians and hospital executives with low-performance scores typically revamped their protocols in response to these data.[11] Most studies found that the fears that surgeons would aban-

don 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.[12] (Although one 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."[13])

Public performance disclosure is important. 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.[14] 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 of the patient care procedures.[15] A study of obstetrics performance found that hospitals whose results were disclosed publicly had significantly greater improvement than those with private reports, while an equal percentage of those with no reports improved and declined significantly.[16]

The Impact of Information on How Markets Work

How do consumers cause products to be better and cheaper?

Paradoxically, although average buyers are not experts about most of their purchases, consumers can reshape entire industries, even those with complex, technical products, such as financial services, cars, or computers. The reason is that markets are guided not by average consumers but by the marginal, or *last,* customers who drive the toughest bargain. They are the show-me crowd, bloodlessly depicted on the bottom of the Economics 101 downward sloping demand curve. This relatively small group of demanding consumers reward suppliers who reduce price and improve quality. For example, a McKinsey study showed that only 100 investors "significantly affect the share prices of most large companies."[17]

Below I will illustrate how relatively few consumers, when they were armed with information, transformed the complex goods and services in the automobile and finance sectors.

The Impact of Information on the Automobile Sector

Consider the purchase of a car. Most consumers have only the dimmest notion of how a car functions. After all, a car is a high-tech device, studded with microchips. 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?"

My own 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. Nevertheless, I can readily find the kind of car I want at a price I am willing to pay. My quality choices have increased substantially since 1966, while the cost of a car has decreased as a proportion of income:[18] As a result, 48% of the poor own cars, and 14% own more than one.[19]

How can an average consumer easily find cars that are better and cheaper?

And, as only one person in a vast sea, why is she not pillaged in the automobile market?

The answer to these questions illuminate how markets work so that even ignorant, weak, solo participant, are offered better and cheaper products. Two ingredients are crucial:

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

I review the rating literature for a car that embodies the attributes I value: safety, reliability, environmental friendliness, and price. Objective, trustworthy information about these attributes is easily available to me. Thus, when I studied *Consumer Reports* for cars with these attributes, two brands caught my eye: Volvo and Buick. I skipped the earnest reviews of how the engines work, fuel-efficiency, comfort, handling, styling, etc. Safety, environmental quality, reliability, and price—these are what interests 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 who shared my views of a car's desired characteristics opted for the Volvo. It grew from an obscure Swedish brand to sales of456,000 cars in 2004.[20] Volvo's rivals saw that a meaningful number of customers were interested in safety and reliability and introduced these qualities into their cars. In the quest for safety,

Ford, for example, acquired Volvo[21] while other automobile manufacturers improved their reliability. By 2005,U.S. cars exceeded European ones in reliability and the Japanese cars had only a small edge.[22] Quite a change from 1980 when U.S. cars were three times as unreliable as Japanese ones and twice as unreliable as European vehicles.[23]

So that is how cars became better even when the consumer is not expert. Information makes them smart.

But what stops the car manufacturers from refusing to cut their prices for only one person?

The critical second ingredient to an effective market is a small group of tough-minded buyers. At a high price, there are only a few buyers who are more-or-less price insensitive. To attract more customers, suppliers reduce their prices. The increased volume of customers more than compensates for the reduction. Suppliers continue to cut prices until they hit a brick wall: the last picky, tough-minded customers who clear the market. At this price, the incremental revenue that providers generate from the hard-nosed bargain shoppers is roughly equal to their marginal cost. The rest of us benefit from the assertiveness of the last-to-buy crowd.

The car market illustrates their impact. Currently, automobile prices are 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 2005, a new vehicle required only 26.2 weeks of their income—a 14% decline.[24] Simultaneously, automobile quality is at an all-time high.[25] The range of choices is better too, as the quality differences between the best and worst manufacturers have declined.[26]

"Efficient" Capital Markets

The securities markets are fabled for their efficiency.[27] But how can security prices reflect the impact of all the complex publicly available information about the performance of each listed firm? As an old accounting teacher, I know that many individuals cannot fully comprehend this complex information.

There are at least two possible explanations. A group's consensus estimate is generally better than that of individuals; as one example, one group of 47 correctly predicted most of the 2006 Oscar winners, including those in obscure categories such as Art Direction, but only one of them matched the consensus for accuracy.[28] Further, expert analysts help investors to evaluate prices, through information freely available in the mass media, on the web, and to clients of brokerage houses. The experts themselves are rated, as in *The Wall Street Journal* "All-Star Analysts'" list. Investors in mutual fund can evaluate their performance in publications such as *Forbes, Money,* and *Consumer Reports,* or the Morningstar and Value Line newsletters.

Investors use these assessments to reward recent good performers, by allocating more money to them.[29] For example, Morningstar's ratings of mutual funds are well correlated with their performance.[30] The growth in information retrieval services—especially in their electronic component—supports the market's continued efficiency.

Competition among sellers of securities also increases the fairness of market prices.[31] For example, when E*Trade first established its own Web site for on-line stock trading, its low commission quickly attracted millions of trades. But, E*Trade's on-line competitors continually bettered its prices, leading to intense competition. As the profit margins of traditional market makers plunged, investors saved billions.[32] Such competition is spurred by comprehensive, easily available evaluations of transaction costs through sites such as SmartMoney.

The vast amount of public information about the security markets enables the intensive scrutiny that also improves their efficiency. For example, a critical academic analysis of the bid-ask price spread on the NASDAQ prompted an SEC investigation and ultimately findings of price rigging. In response, the NASDAQ agreed to spend $100 million to improve its regulation[33] and investors are likely to reap more than $1 billion in settlement of a class-action suit.[34]

The information helps Congress to monitor the markets. But the best, and most important, monitor is the public. As the *New York Times* noted, ". . . It is the rising power of [average amateur American investors pouring their money into mutual funds and retirement accounts that have made] the fairness of stock trading systems a populist political issue. . . . Advances in technology have made it far easier for regulators, professional investors, and even amateurs to figure out who is getting a fair shake."[35]

The impact of information on these favorable market characteristics is highlighted by security markets in developing countries: in early stages of market development, improvements in information convinced creditors to lend more; as the markets matures, firms substituted equity for debt financing. Overall, information lowers the cost of both debt and equity capital.[36]

Health Care Consumers of Information

When it comes to health care, some worry that average consumers will be stymied by the process of selecting relevant information.[37]

Although these analysts fail to appreciate the impact of marginal consumers on a market, they, nevertheless, raise a question: Does a marginal group of tough-nosed, market-clearing consumer not exist in health care?

To explore this, consider the characteristics of American consumers. Current generations are much better educated: In 2004, 27.7% of the population had attained a college education or more and 85.2% were high school graduates.[38] In 1960, in contrast, fewer than half the people were high school graduates and only 7% had a college education.[39]

The former Federal Reserve's chairman, Alan Greenspan, attributed the surge in the U.S. economy's productivity to Americans' 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."[40]

Higher levels of educational attainment increase not only income and ability but also self-confidence (referred to as "self-efficacy" in the health policy literature[41]). Affluent web surfers embody these characteristics—they spend 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.[42] Those who focus on their affluence miss the point: Affluent or not, they eat the same bread, buy the same appliances, and wear the same jeans. The same Toyota is sold in poor inner city areas and affluent suburbs. Their activism improves these products for the rest of us.

Consumers surf the web for health care information too. A 2005 report found that 95 million people used the Internet for health information,[43] 6 million of them daily.[44] Some even study medical 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.[45] A few even express their activism directly by mastering medical skills, such as CPR and the use of external defibrillators.[46]

The assertiveness and self-confidence that typify marginal consumers are evident in these 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."[47] Their pragmatism is apparent too. They do not search idly. More than 70% want online evaluations of physicians,[48] and when they obtain the information, they use it.[49] Consumers are also willing to change hospitals in response to information.[50]

How to Make Health Care Transparency Happen—The SEC

Many knowledgeable observers contend the U.S. Securities and Exchange Commission (SEC) is a critical element of the efficiency of the securities markets.[51] The SEC was created in 1934, during the administration of U.S. President Franklin Delano Roosevelt (FDR), to correct the woeful abuses of small investors in the markets: insider trading, stock watering, nonexistent or misleading information, and outright fraud.[52] FDR had to buck substantial opposition from businesses and state regulators to enact the SEC legislation. His hope was that the SEC would restore public confidence in the markets and succeed where lax, inconsistent, inadequately funded state "blue sky" regulations—meant to check promoters who would sell "building lots in the blue sky"—had failed.[53]

Regulation of securities was not a new idea. As early as 1285, England's King Edward I required licensure of London brokers.[54] Much of this early regulation relied on authorities to evaluate the worthiness of a security before permitting its public sale.[55] But, from its inception, the SEC, unlike its predecessors, was not a "merit" agency. As Roosevelt noted: "The Federal Government cannot and should not take any action that might be construed as approving or guaranteeing that . . . securities are sound. . . ." Rather, the SEC was to insure full disclosure of all material facts about the securities. In Roosevelt's words, "It puts the burden of telling the truth on the seller."[56]

There was plenty of truth waiting to be told. At the time of the SEC's creation, there were minimal requirements for listing of securities on the stock exchange and no source of generally accepted accounting principles. Information disclosure was limited and not subject to oversight. In 1923, only 25% of the New York Stock Exchange firms provided reports to their shareholders.

Sound familiar?

To put teeth in its mission, the SEC was given the power to enforce "truth in securities" (the Securities Act of 1933) and to regulate the trading of securities in markets through brokers and exchanges (the Securities Exchange Act of 1934). Firms that trade their securities in inter-state markets must register with the SEC and file regular information reports. Exchanges and inter-state brokers must also be registered. The SEC also reviews the rules for market operations and requires that brokers meet minimum capital requirements and submit information about their transactions. The 1934 act also protects investors against deceptive practices.[57]

The SEC's powers to regulate information and the functioning of the securities markets are key elements of the efficient U.S. markets.

The Private Sector Sources of Information

The information that lies at the heart of the efficiency of the markets wells from the delicately balanced interaction among three private sector groups: the firms, the FASB (Financial Accounting Standards Board), the accounting information standards promulgator, and the accounting profession.

The presence of three different groups provides checks and balances and fuller consideration of diverse points of view. Unlike a government agency, this troika does not sing out of one hymnal. And their private-sector nature requires political and financial support for their continued existence. If they hit a sour note with their diverse supporters, they can, and have been, forced to change their ways. (For more, see Appendix A.)

The firms that prepare information disclosures are subject to many checks and balances. On the one hand, they must prepare financial statements and other information disclosures that reflect their distinctive economic circumstances. Although they must use FASB standards, these are typically not straitjackets: Similar firms may account for similar circumstances in substantially different ways.[58] On the other hand, corporate executives face substantial legal liabilities and the wrath of the SEC for failure to disclose material events. And if their auditor decides to resign or they decide to switch auditing firms, the SEC requires a public filing and explanation of the reason for the change.[59] The SEC is not perfect. Lax enforcement exacerbated the financial scandals of the 1990's. But our financial markets are widely viewed as world-class in transparency.

Two characteristics are central to its success of the process.[60] First, all the private sector organizations involved must satisfy their constituencies or, like the FASB's predecessors, they will cease to exist. Second, the many participants in the process serve to promote the perspectives of diverse interest groups that are essential for fair and complete information disclosure.

A Health Care SEC

Societal Consequence of SEC-like Health Care Regulation

The U.S. securities markets contain the characteristics desired for the health care:

- Prices are fair in the sense that they reflect all publicly available information, despite the inability or unwillingness of many buyers to avail themselves of this information.
- Buyers use this information to redirect capital so that it rewards productive firms and penalizes unproductive ones.
- Information and competition continually reduce transaction costs.

The presence of these characteristics in health care would achieve two important social goals:

First, they would help the uninsured and the underinsured.

Second, they would divert money from health providers that offer a bad buy to those that offer a good one. The bad buy providers would shrink or improve. The good buy providers would flourish.

How to Make it Happen

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

1. *An Independent Agency with Singular Focus.* The SEC is an independent agency charged solely with overseeing the integrity of securities and the markets in which they are purchased. Because of these organizational characteristics, the SEC's mission is not muddied—it is squarely lined up with the consumer—and it can be held clearly accountable for is performance.
2. *Penalties.* The SEC is armed with powerful penalties for undercapitalized and unethical market participants, including imprisonment, civil money penalties, and the disgorgement of illegal profits. A corresponding health care agency

would oversee the integrity and require public disclosure of information for health care.

3. *Private Sector Disclosure and Auditing.* The SEC relies heavily on private sector organizations, which contain no governmental representation. The new health care agency should similarly delegate the powers to derive the principles used to measure health care performance to an independent, private, nonprofit organization that, like the FASB, represents a broad nongovernmental 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.
4. *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 should require public dissemination of all outcomes for providers, including clinical measures of quality, and related transaction costs.
5. *Focus on Outcomes, Not Processes.* The SEC and FASB focus on measuring the financial performance of organizations. FDR firmly rejected dictating business processes or rating businesses as appropriate roles for the SEC.

The SEC is essentially a profit center, generating a substantial surplus from its filing and penalty fees, which offset its billion dollar budget.

How Not to Make It Happen

Unfortunately, some of the well-intended proposals to achieve transparency in health care undermine one or more of these essential characteristics. All too often, they request that the health care regulator(s) evaluate and micromanage health providers and the markets in which they operate. They would grant the government regulator substantially greater powers than those exercised by the SEC.

- **Government-Controlled Disclosure:** Disclosure requirements would be prepared by governments, not the private sector.

The open FASB process that incorporates professional criteria and the perspectives of many different interest groups would likely be compromised with government promulgation of the measurement yardsticks. After all, while the FASB's private sector status requires the respect and financial support of many constituencies for its continued survival, these are much weaker motivational forces for a monopolisitic agency.

- **Government-Controlled Analysis:** Many proposals require a government agency to prepare benchmarks or standards of achievement, sometimes even a report card.

When health providers are thus required to sing out of the same hymnal, innovations in health care may not be recognized and may well be discouraged. Peer reviewers have delayed the introduction of many important innovations including Barry Marshall's identification of the role of bacteria in ulcers and Judah Falkman's angiogensis theories of tumor growth, by suppressing publication in journals and research funds.

Further, the important role that analysts now play by delineating their many different opinions will be eliminated.

- **Government Micro-management:** Many proposals require health care providers to comply with enormously detailed managerial process requirements.

The likely result? Lack of innovation. Government should disclose prices and outcome, not micro-manage providers.

Role of the Government

This is not to say that government action is not required. To the contrary, the much-abused U.S. health care consumer needs, and wants, government protection. Powerful provider interests oppose transparency, however, and they have powerful political allies. The American Hospital Association, for example, moved its headquarters to Washington, DC, and vastly increased the political contributions of the sector because, as its recently retired head noted, "Of course, the common denominator is money. You're always fighting to protect payment . . ."[61]

But overly zealous governmental intrusion into health care transparency is unlikely to fully achieve the results in care health that the SEC legislation achieved in the securities markets. Indeed, it may inadvertently cause government protection to cross the line from providing helpful information and oversight to causing paralyzing evaluation and micromanagement.[62]

Appendix A

The Three Private Sector Legs of the Financial Transparency Stool

The Firms

Much of the information emanates from the firm itself: Organizations registered with the SEC must disclose both financial and nonfinancial information in routine reports, including the firm's financial statements; management's discussion and analysis of performance; disclosure of the top executives' compensation; and evaluation of the firm's various lines of business.

Although the firm's managers prepare this information, they must use the methods promulgated by the FASB and its predecessors to measure some financial statement items. (The SEC had legal authority to specify these accounting standards but, with active oversight, it generally relies on the FASB to do so.)[63] The managers hire an independent accounting firm to audit whether the financial statements have been prepared in accordance with the generally accepted accounting principles (GAAP) as defined by the FASB and others. The generally accepted auditing standards that guide the process have been defined by the American Institute of Certified Public Accountants' Auditing Standards Board.[64] The auditors render a formal opinion of the firm's financial statements. If the information deviates from GAAP, or if the auditor cannot issue a clean opinion for other reasons, the SEC may well suspend trading in the stock and thus bar the firm from access to the capital markets.

The FASB

Because the FASB is a private, nonprofit organization, it lacks the stability of tax-financed government organizations. To survive, it must earn sufficient revenues to cover its expenses and the respect of its constituency. These results are not so easily achieved: Two predecessor organizations to the FASB folded in part because they could not reach a politically acceptable consensus on specific accounting standards.[65]

The FASB was designed to remedy some of the structural problems of its predecessors.[66] Unlike them, it was an independent, well-funded organization, sponsored by a nonprofit foundation whose board represents auditors, businesses, users, and the public.[67] To provide independence, the FASB's board members serve a full-time, five-year term at handsome rates of pay.[68] Although they are all well-versed in accounting, they come from diverse backgrounds, including partners in large and small accounting firms, financial analysts, accounting academics, and industry.[69]

In recognition of the political, consensus-building nature of its mandate, the FASB's process for issuing an accounting standard elicits widespread, thoughtful responses. The process is completely public. Repeated rounds of exposure drafts encourage wide participation.

As a result of the open, elaborate standard-setting process, FASB's standards incorporate diverse points of view in an acceptable political consensus. This process is crucial to the FASB's success. Although accounting techniques were codified in 1494 by the mathematician Luca Pacioli,[70] as in health care, a conceptual foundation that can clearly adjudicate all measurement disputes still does not exist.[71] As a FASB chairman noted, "Accounting, like law, is an art whose rules are not susceptible to . . . tests of validity . . . Accounting is rather a convention supported by general acceptance, consensus."[72]

The Accounting Profession

The independent accountants who audit the financial statements represent yet another important check and balance in the process of providing information.

Certified accountants are professionals who must fulfill stringent examinations and educational requirements.[73] They frequently work in one of the Big Four accounting firms. Accounting firms can be held legally liable for negligence, fraud, and breach of contract.[74] Accountants have been found criminally liable for misstatements in cases even where they did not directly benefit from them.[75]

Accountants are thus subject to three powerful pressures: Their profession's standards of ethics,[76] the marketplace (accountants must satisfy their clients, the corporations that hire them), and their legal liability.

Endnotes

[1] Government Accounting Office (GAO), *Federal Employees Health Benefits Program,* GAO Highlights, August 2005.

[2] "Hospital Stays of Uninsured Stable: AHRQ," *Modern Healthcare* (June 5, 2006).

[3] "Catholic Healthcare West Agrees to Refund Uninsured Patients," San Francisco Chronicle (June 15, 2006): B2

[4] *Competition in the FEHB Program.* Hearing, Committee on Ways and Means, December 2, 2005. Testimony of Richard L. Blomquist, President, Blomquist Benefits Consulting, Milwaukee, WI.

[5] A.L. Robinow, "The Buyers Health Care Action Group: Creating Incentives to Seek the Sick," in R.E. Herzlinger, *Consumer-Driven Health Care* (San Francisco: Jossey Bass, 2004), pp. 309–316.

[6] CMS, "Medicare Part D Spending Projections Down Again," CMS Office of Public Affairs (July 11, 2006).

[7] M.R. Chassin et al., "The Urgent Need to Improve Health Care Quality," *Journal of the American Medical Association,* 280:11 (September 16, 1998): 1003; D. Mukamel and A. I. Mushlin, "Quality of Care Information Makes a Difference," *Medical Care* 36, 7 (July 1998): 945–954; J. H. Hibbard, J. Stockard, and M. Tusler, "Hospital Performance Reports: Impact On Quality, Market Share, and Reputation," *Health Affairs,* 24:4 (July/August 2005): 1150–1160; and J. K. Barr, C. E. Boni, K. A. Kochurka, P. Nolan, M. Petrillo, S. Sofaer, and W. Waters, "Public reporting of hospital patient satisfaction: the Rhode Island experience," *Health Care Financr Review,* 23:4 (Summer 2002): 51–70.

[8] N. C. Churchill and V. Govindarajan, "Effects of Audits on the Behavior of Medical Professionals under the Bennett Amendment," *Auditing* 1 (Winter 1982): 69–90; and S. E. Kaplan, K. Menon, and D. D. Williams, "The Effect of Audit Structure on the Audit Market," *Journal of Accounting and Public Policy,* 9:3 (Fall 1990): 197–201.

[9] P. S. Romano, J. A. Rainwater, and D. Antonius, "Grading the Graders," *Medical Care,* 37:3 (March 1999): 295–305; J. M. Bentley and D. B. Nash, "How Pennsylvania Hospitals Have Responded to Publicly Released Report on CABG," *Joint Commission Journal on Quality Improvement,* 24:1 (1998): 40–49; California Institute for Health Systems Performance and the California Health Care Foundation: Results from the *Patients' Evaluation of Performance (PEO–C) Survey: What Patients Think of California Hospitals,* 2001; D. R. Longo, G. Land, W. Schramm, et al., "Consumer Reports in Health Care: Do They Make a Difference in Patient Care?" *Journal of the American Medical Association,* 278:19 (Fall 1997): 1579–1584; J. A. Rainwater, P. S. Romano, and D. M. Antonius, "The California Hospital Project: How Useful is California's Report Card for Quality Improvement?" *Joint Commission Journal on Quality Improvement,* 24:1 (1998): 31–39; G. E. Rosenthal, P. J. Hammar, L. E. Way, et al., "Using Hospital Performance Data in Quality Improvement: The Cleveland Health Quality Choice Experience," *Joint Commission Journal on Quality Improvement,* 24:7 (1998): 347–359; and D. P. Smith, G. Rogers, A. Dreyfus, et al., "Balancing Accountability and Improvement: A Case Study from Massachusetts," *Joint Commission Journal on Quality Improvement,* 26:5 (2000), 299–312.

[10] E. L. Hannan, A. L. Siu, D. Kumar, and M. R. Chassin, "The Decline in Coronary Artery Bypass Graft Surgery Mortality in New York State," *Journal of the American Medical Association,* 273:3 (1995): 209–213; S. W. Dziuban, "How a New York Cardiac Surgery Program Uses Outcome Data,"*Annals of Thoracic Surgery,* 58:6 (1994): 1871–1876.

[11] M. R. Chassin, "Achieving and Sustaining Improved Quality: Lessons from New York State and Cardiac Surgery," *Health Affairs,* 21:4 (July/August 2002): 40–51.

[12] 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): 993–999.

[13] D. Dranove, D. Kessler, M. McClellan, and M. Satterthwaite, "Is More Information Better? The Effects of 'Report Cards' on Health Care Providers," *Journal of Political Economy,* 111: 3 (June 2003): 555–588.

[14] "Health Plan Report Cards May Influence Insurers More than Consumers," Findings Brief, *Health Care Financing & Organization,* 3:3 (April 2000).

[15] J. M. Bentley and D. B. Nash, "How Pennsylvania Hospitals Have Responded to Publicly Released Report on CABG," *Joint Commission Journal on Quality Improvement,* 24:1 (1998): 40–49.

[16] J. H. Hibbard, J. Stockard, and M. Tusler, "Hospital Performance Reports: Impact On Quality, Market Share, and Reputation," *Health Affairs,* 24:4 (November/December 2005): 1156–1166.

[17] K. P. Coyne and J. W. Witter, "What Makes Your Stock Prices Go Up and Down," *The McKinsey Quarterly,* 2 (2002): 29–39.

[18] U.S. Census Bureau, *Statistical Abstract of the United States: 2006,* Washington, D.C. (2005): 637, Table 962.

[19] Auto Affordability Index, http://www.Comerica.com, accessed 17 January 2006.

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

[21] K. Kerwin, "At Ford, the More Brands, the Merrier," *BusinessWeek,* no. 3675 (3 April 2000): 58.

[22] C. Tierney, "Asian Auto Brands' Reliability Uneven; Chevy Monte Carlo, Mercury Mariner SUV Rank Among Most Dependable in *Consumer Reports* Survey," *The Detroit News* (October 27, 2005): 1C; and S. Silke Carty, "Japanese Brands Show 'Nicks,'" *USA Today* (October 27, 2005): 5B.

[23] "Twenty Years of *Consumer Reports* Surveys Show Astounding Gains," *Consumer Reports* (April 2000): 12.

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

[25] J. D. Power, "Initial Quality Study," 2005. http:/consumercenter.jdpower.com/cc/rd/cc/global/content/ratingsguide.asp, accessed 27 January 2006.

[26] J. D. Power, "Initial Quality Study," 2005. © 2005 J.D. Power and Associates. All rights reserved.

[27] Eugene Fama first proposed three definitions or standards to test the efficient market hypothesis: weak, semi-strong, and strong. The strongest form of the efficient markets hypothesis asserts that all information known by market participants is fully reflected in market prices so it is impossible for insiders who trade on private information to earn abnormal profits. (M. A.

Joy, "Hunting the Stock Market Snarks," *Sloan Management Review,* 3:28 (Spring 1987): 22.) While it is not impossible for insiders to profit from information, for the most part, the stock market comes very close to meeting the strongest standard for efficiency (Joy, *op. cit.* See also, for example, M. Jensen, "Risk, the Pricing of Capital Assets, and the Evaluation of Investment Portfolios," *Journal of Business,* 42:2 (April 1969): 167–247).

[28] "Here's How Our Staff Picks 'em," *Chicago Daily News* (November 25 1996): 43.

[29] R. A. Ippolito, "Consumer Reactions to Measures of Poor Quality: Evidence from the Mutual Fund Industry," *Journal of Law and Economics,* 35:1 (April 1972): 45–70. B. G. Malkiel, *A Random Walk Down Wall Street* (New York: W.W. Norton & Company, 1996), 443–444.

[30] M. Hulbert, "Positive Ratings for a Ratings Makeover," *The New York Times* (January 15, 2006): 6.

[31] Rebecca Buckman, "Cyber-Sleuths," *Wall Street Journal* (August 4, 1998): C1.

[32] Matthew Schifrin with Scott McCormack, "Free Enterprise Comes to Wall Street," *Forbes* (April 6, 1998): 114–119. Gretchen Morgenstern, "Surrender," *Forbes* (April 6, 1998): 120. Matthew Schifrin, *op. cit.,* p. 116.

[33] Laura Holson and Diana Henriques, *op. cit.,* p. A1.

[34] "Collusion in the Stock Market," *The Economist* (January 17, 1998): 71.

[35] Leslie Eaton, *op. cit.*

[36] Asli Demirquc-Kunt and Vojislav Maksimovic, "Stock Market Development and Corporate Finance Decisions," *Finance & Development,* 33:2 (June 1996): 47–49.

[37] J. M. Lambrew, "Choice in Health Care: What do People Really Want," Issue Brief, The Commonwealth Fund, New York, September 2005. Of course, excessive choice may not be helpful. See, for example, B. Schwartz, *The Paradox of Choice: Why More Is Less* (New York, NY: ECCO, 2004)**.** But markets typically solve this problem: suppliers narrow down choices to those that generate the best consumer response.

[38] U.S. Census Bureau, *Statistical Abstract of the United States: 2006* (Washington, DC: Government Printing Office, 2006): 147.

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

[40] "State of the Economy," *Federal News Service* (January 20, 1999).

[41] J. H. Hibbard, E. M. Peters, P. Slovic, and M. Tusler, "Can Patients Be Part of the Solution? Views on Their Role in Preventing Medical Errors," *Medical Care Research and Review,* 62:5 (October 2005): 601–616.

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

[43] *Health Information Online,* Pew/Internet and American Life Project (May 2005): ii.

[44] S. Fox and L. Rainie, *How Internet Users Decide What Information to Trust,* www.perInternet.org/reports/pdfs (May 2002).

[45] PricewaterhouseCoopers, *HealthCast 2010* (New York, NY: PricewaterhouseCoopers, November 2000), 22; S. Reents, *Impact of the Internet on the Doctor-Patient Relationship: The Rise of the Internet Health Consumer* (New York, NY: Cyber Dialogue, 1999): 4, http://www.cyberdialogue.com/ pdfs/wp/wp-cch-1999-doctors.pdf.

[46] "Just Another Day at the Office," *USA Today* (April 16, 2001): 1–2b.

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

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

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

[50] S. Sofaer, C. Crofton, E. Goldstein, E. Hoy, and J. Crabb, "What Do Consumers Want to Know about the Quality of Care in Hospitals?" *Health Serv Res.,* 40:6 (Pt 2) (December 2005): 2018–2036.

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

[52] Fred Skousen, *An Introduction to the SEC* (Cincinnati, Ohio: South-Western Publishing, 1991): 118. U.S. Securities and Exchange Commission, "Good People, Important Problems and Workable Laws: 50 Years of the Securities and Exchange Commission" (Washington, D.C.: The Commission, 1984).

[53] Joel Seligman, *op. cit.,* pp. 44–46.

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

[55] Arguably the most famous, or notorious, of this kind of regulation was the 1720 Bubble Act that required the personal approval of the English monarch for all corporate charters. The act resulted from the financial panic induced by the pricking of a speculative bubble that had buoyed the stocks of many newly incorporated English firms. In 1720, the South Sea Company's stock, for example, rose from ₤130 to more than ₤1,000, only to collapse when the company's directors began to sell their shares (Burton G. Malkiel, *op. cit.,* pp.40 44).

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

[57] Fred Skousen, *op. cit.* pp. 22–28.

[58] See, for example, "The Firm's Selection of Alternative Accounting Principles," in Clyde P. Stickney, Roman L. Weil, and Sidney Davidson, *Financial Accounting* (Orlando, Florida: Harcourt Brace Jovanovich, 1991): 800–802.

[59] GAO, *op. cit.,* pp. 44–45.

[60] To the contrary, critics abound. Some complain about the excessive amount of information disclosed and urge adoption of the more Spartan disclosure policies used abroad (See, for example, Ray J. Groves, "Financial Disclosure: When More Is Not Better," *Financial Executive,* 10:3, (May 1994): 11). Others note the paucity of disclosure abroad and complain that, even in the United States, disclosure is hobbled. They contend that the SEC's choice to focus on preventing misleading financial statements, rather than informative disclosure, has created a "climate of conformity" that inhibits experiments in financial accounting (Stephen A. Zeff, "A Perspective

on the U.S. Public/Private Sector Approach to the Regulation of Financial Reporting," *Accounting Horizons,* 9:1 (March 1995): 52–70).

[61] "Davidson set AHA on New Path: Association Became Focused on Lobbying Congress," *Modern Healthcare* (April 17, 2006): 7.

[62] This testimony is partially based on "Protection of the Health Care Consumer: The 'Truth' Agency." (Washington, D.C.: Progressive Policy Institute, March 1999), and U.S. Congress, House Committee on Ways and Means, Oversight Subcommittee, Hearing on Pricing Practices of Hospitals, Testimony, June 22, 2004.

[63] Paul W. Miller, Rodney J. Redding, and Paul R. Bahnson, *The FASB: The People, the Process, and the Politics* (Burr Ridge, Ill.: Richard D. Irwin, 1994): 20–21.

[64] Coopers & Lybrand, "Independence Standards Board," *Audit Committee Update 1998* (Jersey City: Coopers & Lybrand, 1998): 20–21.

[65] The Accounting Principles Board (APB), the FASB's immediate predecessor, collapsed in 1973, in some measure because of disagreement with its proposed accounting treatment for business combinations and an earlier opinion on tax credits. In the latter case, the APB proposed to defer recognition of some of the benefits of the credit. Although the APB's standard conformed with accounting theory, three accounting firms announced they would not comply with the opinion. Even the SEC decided that its registrants need not follow it. Absent the support of business, the accounting community, and the SEC, the APB found its authority to set accounting standards severely eroded (Gary John Previts and Barbara Dubis Marino, *A History of Accounting in America* (New York: John Wiley, 1979): 290–291). Some also worried about the APB's excessively close ties to the accounting institute; its sponsors; its large, 17-member board; and the continued allegiance of its part-time board members to their employers or clients (Paul W. Miller, Rodney J. Redding, and Paul R. Bahnson, The FASB (Burr Ridge, Ill.: Richard D. Irwin, 1994): 56. Marshall S. Armstrong, "The Politics of Establishing Accounting Standards," *The Government Accountants Journal,* 25:2 (Summer 1976): 8–13.

[66] Paul W. Miller et. al., *op. cit.,* pp. 30–58.

[67] Paul W. Miller et al., *op. cit.,* p. 35.

[68] Financial Accounting Foundation, *op. cit.,* p. 24.

[69] Stephen Barr, *op. cit.*

[70] Gary John Previts and Barbara Dubis Merino, *A History of Accounting in America: An Historical Interpretation of the Cultural Significance of Accounting* (New York: Wiley, 1979): 6.

[71] Although such a conceptual foundation theoretically exists—currently, it takes the form of six concept statements that cover issues such as the Elements of Financial Statements (Cheri L. Reither, "How the FASB Approaches a Standard-Setting Issue," *Accounting Horizons* , 11:4 (December 1997): 91–104) in practice, debates about fundamental accounting issues—such as current vs. historical costs value or capitalization vs. expensing—continue to roil the profession (Miller, op. cit., "Some Recurring Accounting Controversies," pp. 114–127).

[72] Marshall Armstrong, *op. cit.,* p. 10.

[73] U.S. General Accounting Office (GAO), *The Accounting Profession* (Washington, D.C.: Government Printing Office, September 1996): 89–90.

[74] Gary Previts and Barbara Marino, *op. cit.,* p. 204.

[75] Fred Skousen, *An Introduction to the SEC* (Cincinnati, OH: South-Western Publishing, 1991): 128.

[76] Gary Previts and Barbara Marino, *op. cit.,* pp. 314–315.

Chairman JOHNSON OF CONNECTICUT. Ms. Downey, welcome.

STATEMENT OF ROBIN DOWNEY, PRODUCT DEVELOPMENT HEAD, AETNA, MIDDLETOWN, CONNECTICUT

Ms. DOWNEY. Good morning, Madam Chairman and Members of the Committee. My name is Robin Downey. I am Vice President and Head of Product Development for Aetna.

As one of the Nation's leading health care companies, we include about 15 and a half million health care members in our plans today; and I am very pleased to be here to be able to talk to you about transparency in health care.

Nearly 5 years ago, Aetna was the first health insurer to offer a consumer-directed product which fully integrated health plans with Health Reimbursement Arrangements. By the authorization of Health Savings Accounts (HSAs) by Congress at the end of 2003, we were again the first to announce our HSA offering. Today, our membership in HSA and Health Reimbursement Arrangement (HRA)-style plans is nearly 600,000 Americans. That experience

gave us early insight into consumers' need for information necessary to manage their health care.

Today, I would like the share with you our experience in introducing both price and quality transparency to our members but not just those in a consumer-driven health plan, a consumer direct HRA or HSA. Points-of-service, Health Maintenance Organization (HMO), and Preferred Provider Organization (PPO) plan members also share in the cost of their health care through deductible and coinsurance.

I am sure many of you are aware that many consumers today think that office visits cost $15 and drugs cost $2 and $5. In a recent survey that we did with members of Aetna, members in one community, 95 percent of them responded that information on price would be very useful. Seventy percent of the physicians we surveyed in the same community didn't understand why that information would be helpful to their patients. These responses reflect a significant gap in understanding the impact that today's health benefit plans have on consumers' need for information to help manage their health care spending.

For a number of years, health plans like Aetna have been providing members with ranges of physician costs and hospital costs by geographic area showing the differences between in and out of network. We also reflect episodic costs, how much might it cost if I had a baby, much how much might it cost if I had asthma or diabetes in a total year. This was important to help consumers plan for their health care costs. How much money to put in HSA, how much to put in Flexible Spending Account (FSA), allowing them to make plans for things they had not been able to plan for in the past.

As more members began to be engaged in moving to consumer direct plans, it became apparent that they should have more information on costs. Our CEO felt it was time to open up the black box and provide physician-specific unit price detail, not just ranges or averages but what the health plan actually negotiates and pays to the providers so that the members can have that information before they go for their visit.

So, in August of 2005, Aetna announced that we would be the first health plan to provide our members with the on-line access to the actual discounted rates for the most common office-based procedures provided to primary care and specialist physicians.

The physician costs were selected first as they were they really impact more consumers than hospitals, and they are easier to understand, but it is just the first piece of what we need to do.

The greater Cincinnati market that was chosen as the pilot and collaboration with the medical community, was very important. We began meeting with large physician groups and medical societies. We also conducted more than 20 focus groups with physicians and office staff and incorporated their feedback from these meetings into the program. So, via our password protected Web site, we provided rates for office visits and other services, up to 25 by specialty.

Since the launch of transparency in Cincinnati, between 600 and a thousand consumers a month have visited the Web site. As we met with physicians that we surveyed, they were clear that patients needed enough information to make decisions based on over-

all value, not simply price alone. So, based on their feedback, we felt it was important to expand our transparency efforts to provide consumers with information on quality and cost efficiency. Since we have been designating specialists into our High Performance Network based on clinical performance and cost efficiency since 2004, the integration of this information along with unit price transparency was a logical next step.

Last month, we announced that we would be expanding our health transparency initiatives to include price, clinical quality and efficiency transparency in all or parts of seven States and the District of Columbia. We will also expand unit price transparency alone in three markets. The resulting clinical quality and efficiency information will be available to nearly 15,000 specialists, and specific pricing will be available on more than 70,000 physicians.

Aetna will continue to work with employers, providers and legislators to push the envelope on health care transparency. We expect to expand the program by the fall of 2007 to additional markets and enhance it with new information, including hospitals and ancillary providers over time.

Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Ms. Downey.

[The prepared statement of Ms. Downey follows:]

Statement of Robin Downey, Product Development Head, Aetna, Middletown, Connecticut

Good afternoon, Madam Chairwoman and members of the Committee. I am Robin Downey, Vice President and Head of Product Development for Aetna. I'm very pleased to be here today, and to describe to you Aetna's experiences with transparency in health care.

As one of the nation's leading diversified health care benefits companies, Aetna is proud to serve approximately 28.3 million people, including 15.4 million medical members. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans and government-sponsored plans.

Nearly five years ago, Aetna was the first national health insurer to offer a consumer-directed product which fully integrated health plans with Health Reimbursement Arrangements (HRAs). The authorization of Health Savings Accounts (HSAs) by Congress at the end of 2003 provided a critical extension of this concept, permitting employees to defer their own money into a similar, tax-advantaged health spending account that was also portable. Aetna's membership in HRA and HSA-compatible High-Deductible Health Plans currently includes nearly 600,000 Americans.

Today, I plan to share with you Aetna's experiences in introducing price and quality transparency in the health care sector—a topic that is particularly relevant as more and more Americans join consumer-directed plans.

As you are all aware, consumers have long been shielded from the actual cost of health care. Many consumers think office visits cost $15. However, this is beginning to change as consumers begin to share more of the cost through deductibles and co-insurance. As a result, they want information to educate and help them manage the cost.

As reported in the *Wall Street Journal* in February[1] and June[2] of 2005, knowing the cost of a doctor's visit has long been a missing piece of the health care decision-making process. More recently, 84 percent of Americans agreed that hospitals, doc-

[1] *Patients paying for medical care struggle to divine the costs, Wall Street Journal Online, 2.16.05*

[2] *Patients Give New Insurance Mixed Reviews—Consumer-Directed Health Plans Can Cut Costs, but Early Users Cite Problems Comparing Prices, Wall Street Journal, 6.14.05*

tors and pharmacies should publish their prices for all goods and services.[3] And, in a recent Aetna survey in Cincinnati, 95 percent of members surveyed responded that information on price would be useful, but 70 percent of physicians felt it wasn't useful for their patients. These responses reflect a significant gap in understanding the impact that today's health benefits plans have on a consumer's need for information to help manage their health care spending.

Enter an emerging health care trend known within the industry as "price transparency." Through price transparency, consumers know what they can expect to pay at their physician's office *before* the visit. While this approach sounds sensible, no health insurer had ever provided physician specific unit price detail to its members. The reasons for this were varied—contractual issues, competition and complexities in the rates physicians agree to accept from insurers, concerns about consumers shopping for health care on price alone.

That changed in August of 2005, when Aetna announced that we would be the *first* health plan to provide our members with online access to the actual discounted rates for the most common office-based procedures provided by primary care and specialist physicians.

Price Transparency in Cincinnati

Aetna's price transparency initiative responded to a call for help. The employer and broker communities asked us for our help in educating consumers about the actual costs of medical care. Despite the fact that we already offered our members a wide variety of information on health issues, health care quality, and average pricing within specific geographies, the increase in adoption of consumer-directed plans necessitated more detailed information.

After considering a variety of options, we determined that the time was right to offer physician-specific price information. The question was, how to do it in a way that was meaningful to consumers and respectful to the medical community?

One of the keys to successful implementation was testing the program on a limited pilot basis, allowing us to solicit feedback and expand and enhance the initiative over time. The greater Cincinnati market was chosen as the test market for a variety of reasons.

Collaboration also would be key. As the pricing tool was built, our medical directors and network professionals in the Cincinnati market began meeting with large physician groups and medical societies. We also conducted more than 20 focus groups with physicians and office staff. Feedback from these meetings and focus groups—including changes in the terminology used with members, intense member education, and intense physician communication—were incorporated into the program.

The Launch

On August 18, 2005, Aetna launched price transparency. The initiative was well-publicized in the media, receiving significant attention from the *Wall Street Journal, ABC World News Tonight,* and *National Public Radio.* These media stories helped educate consumers, employers and physicians about not only Aetna's efforts, but the trend towards transparent pricing in health care.

With the launch of our pilot, consumers could research what they could expect to pay at the doctor's office *before* going in for a visit. Available via the Aetna Navigator password-protected member website (www.aetna.com), the tool includes rates for 5,000 physicians and physician groups.

Members access pricing via our "DocFind" physician search engine. Rates are currently provided for office visits, diagnostic tests, minor procedures and other services. In all, rates are offered for up to 25 services by specialty and, considering the variations in services among specialties, the tool contains rates for 600 services in all.

The Results

Since the launch of price transparency in Cincinnati, between 600 and 1,000 consumers a month have visited the price information. Increased usage happens at two specific times—as consumers choose their new benefits for the year ahead (typically in the fall) and as consumers begin to use their new benefits (typically in January). While it's too early to say whether consumer behaviors have changed in Cincinnati, we believe that simply raising awareness about the costs of care is one more step in creating a marketplace for consumers as health care decision-makers.

Beyond consumers, we have spent months soliciting feedback from physicians, employers and policy-makers. Physician research was conducted in Ohio, Connecticut,

[3] *Council for Affordable Health Insurance, 5.06*

Washington, D.C. and Florida. Overall, physicians have provided constructive comments on improvements to the program, employers have been keenly interested in our plans to expand the program to their employees, and policymakers have asked to learn more about our experiences. In addition, Aetna's move towards price transparency has been hailed by the media as a "watershed in the evolution of a health care policy in the U.S."[4]

The Evolution of Health Care Transparency

Clearly price transparency is only the beginning. As we met with and surveyed physicians across the country, they were very clear that their patients needed enough information to make decisions based on overall value, not simply price alone. Based on their feedback, we felt it was very important to expand our transparency efforts to provide consumers with information on quality and cost efficiency. Since we have been designating specialists into our High Performance Network based on clinical performance and cost efficiency since 2004, the integration of this information along with unit price transparency was the logical next step.

Aetna's High Peformance Network: Aexcel

Let me provide some brief background on our Aexcel High Performance Network Option. On January 1, 2004, Aetna launched its High Performance Network, featuring Aexcel-designated specialists, in three markets. Health care costs were continuing to rise, and employers were asking for solutions to help mitigate costs while maintaining access to quality care. In addition, consumers often have little access to independent, objective information when they choose specialists. Aetna worked closely with some of its largest customers to create a network option that would meet their needs and also offer consumers information to help them make more informed health care decisions. The result is Aetna's High Performance Network which focuses on medical specialties that represent a high percentage of medical services and costs.

Aexcel-designated specialists have met established thresholds for certain clinical performance and cost-effectiveness measures. Currently, the Aexcel-designation process applies to 12 medical specialties. Doctors within these specialties are evaluated against measures that include the number of Aetna patients treated, clinical performance, efficient use of health care resources and, finally, access to care. Measures include unexpected adverse health events and a specialist's rate of his or her patients' hospital readmissions over a 30-day period.

Aetna's High Performance Network has been very well-received. Based on employer interest, we expanded its availability to include a total of 20 markets this year, with 7 additional markets recently announced to be effective 1/1/07. We currently have 35 customers with 483,000 members enrolled in Aexcel and fully expect continued growth.

Next Steps

Just last month, Aetna announced that we would be expanding our health transparency initiatives to include price, clinical quality and efficiency transparency in all or parts of 7 states and the District of Columbia, and price transparency alone in an additional 3 states. The clinical quality and efficiency information is based on the Aexcel designation. Marrying unit price with Aexcel data helps consumers and employers make decisions based on overall value.

When these enhancements go live on August 18 of this year, clinical quality and efficiency information will be available for nearly 15,000 specialist physicians, and specific pricing will be available for more than 70,000 physicians. In addition, we will be expanding our pricing tool to include up to 30 procedures per physician with the addition of major procedures to the list of available services.

Aetna will continue to work with employers, providers and legislators to push the envelope on health care transparency. We expect to expand the program to additional markets and enhance it with new information, including hospitals and ancillary providers over time.

Chairman JOHNSON OF CONNECTICUT. Mr. Evans.

[4] *A Worthy Experiment, The Cincinnati Post, 8.22.05*

STATEMENT OF DANIEL F. EVANS, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CLARIAN HEALTH PARTNERS, INDIANAPOLIS, INDIANA

Mr. EVANS. Thank you, Madam Chairwoman.

I appreciate the opportunity to appear again before the Committee, and I am looking forward to the questions after the principal statements.

Thank God for Blackberries. I think I might have answered one in the last 2 minutes, but I am not a hundred percent sure.

As I said before in March and later, I am at the retail end of the business, so I deal with the customer and his or her family, the patient, every day. So, the issue of transparency when you work in a building in which you were born and your friends and neighbors call you and ask the very questions this Committee has asked are not academic to me at all. They are serious, very serious.

So, how do I define transparency and value? To what end do we do it? I am eager for the Committee's reaction to this either now or, of course, later.

I define quality as a value, as cost divided by quality. So, I don't think the patient, regardless of the level of transparency, can factor into a decision-making process an important decision about health care as long as they are not being hauled into the ER, as Mr. Stark said, without knowing both of those things. So, transparency has to have both data points in it, both the cost and quality.

Our challenge is, as Mr. Stark saw on the Internet site, we serve multiple constituencies, from people who pay for a mammogram, who go to the clinic that is run by our university, to people that are fully insured, like our own employees who pay, by the way, nothing for the mammogram, to the woman who walks in the off the street and pays $146 for that mammogram.

So, what would we put on our Internet site? Fair question. Then the question is, if I am the customer, when will it be read? By whom? What is the follow-up procedure if there is an abnormality?

As the son of a cancer survivor, I take this breast cancer survivor—I take this beyond seriously, because I know what happens in the home when there is an abnormality in the first reading. Since those are the friends that call me and want to know when it is going to be read by somebody else later on in the day; and, the tenure of the conversation changes. At that point, as Mr. Stark said, choice becomes less important, but, believe me, quality becomes a lot more important. The number of false positives, for instance, is not a good thing in health care and drives down quality and increases cost.

So, we are trying to develop the program that I had in my written testimony where we can give people choice based upon the value proposition and quote them a price that is adjusted to their own situation, such as high blood pressure. What is going to be the cost for you and post that kind of data.

So, we are working on an experiment right now to make the data—I think as the Committee would agree and as an old lawyer would say—used and useful. Will the data on the Internet and elsewhere be used and will it be useful?

When I came in, we had just thrown up some quality data on the Internet site, very serious operations. The patients that look at

that data are highly motivated, and what we found out was that we got 4,000 to 5,000 hits per day of people that stayed an average of 27 minutes each. So, these were people who were deep into the data and wanted to know what the facts were for mortality data at our institution. Well, this is not easy, and we need the help of Congress and the regulator to do this.

Here is my exemplar of that, anticipating the wrong question from Mr. Stark, of course. When I left my office last night, I called the chief gastroenterologist, asked him to come to my office. He runs a staff of hundreds, has endoscopic suites all over central Indiana. I pulled out my card from my wallet, put it on my desk and said, John, how much is this colonoscopy I am going to get at your office tomorrow going to cost? He laughed. He said, you tell me. So, we put his office manager on the speaker phone because his office manager didn't know what was going on; and he said, what part of the colonoscopy? I said, the whole thing.

So, Mr. Stark, here was his answer. He said, well, we got the doc, who bills on form 1500, whatever that is. I have since found out what it is. It is some mandated bureaucratic form that docs bill on. Then you have got the endoscopic suite, the building where it actually occurs. Then you have got the lab, for God's sake, because you might find a polyp and do a polypectomy; and then you got the lab doc, the pathologist who reads it. So, there are at least four pieces.

Now at Clarian, in our outpatient place, I bet we are not different than everybody else here. We send you the bill that says that is not a bill; then the insurance sends you a bill, says this is not a bill, an Explanation of Benefits statement. Then, by the time you get to third piece of paper, you might get a bill that is netted out, but you probably get a fourth that will have the true net bill on it. So, four times four is sixteen. So, what we would like to do in the program that I put in my written testimony is to see if we can combine those.

So, if Mr. Smith calls from Washington and says, I want to know what a colonoscopy in Indiana is going to cost, I am having a speech there, I am having some problems, I will be there tomorrow, we are able to say two grand, Mr. Smith, unless there are—you have got other comorbidities we identify.

What we are trying to do is say, normal vaginal delivery, this is what it is going to cost; 3 days most acute care for the baby, this is what it's going to cost, and this is a revolution.

As you know, what I am finding out and it has humbled me, frankly is how hard this is and how much the industry and others use the regulatory network and scheme to actually retard our ability to bring things together.

So, I hope you see in here that when Mr. Stark gets on at the end of the year, and I know he will, now I know he will, so I am going to be sure it is done, that by January or February somebody could enter into the Web site "colonoscopy charges, normal, healthy, adult male, give me an estimate here." So, that is what we are trying to do, and I am asking for support and comfort as we try to blend those streams of paperwork together.

Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Evans.

[The prepared statement of Mr. Evans follows:]

Statement of Daniel F. Evans, Jr., President and Chief Executive Officer, Clarian Health Partners, Indianapolis, Indiana

Madam Chairman and distinguished members of the Committee, good afternoon, and thank you for the opportunity to comment on price and quality transparency in the health care sector. I am Dan Evans, CEO of Indianapolis-based Clarian Health Partners, a private, non-profit health center serving patients from across the state of Indiana through more than 73,000 annual admissions and over 1.3 million outpatient visits. Clarian is the state's only academic medical center, and is currently conducting 4,000 peer-reviewed research projects.

Clarian is Indiana's largest and most comprehensive health center and is one of the busiest hospital systems in the nation. Clarian employs nearly 13,000 people, and owns or is affiliated with 15 hospitals and health centers throughout Indiana. The Clarian-affiliated Indiana University School of Medicine educates the second largest medical student body in the United States. We have been ranked as one of the top American hospitals by *U.S. News & World Report* for the past eight years, and last year led the nation in solid organ transplant volume. Additionally, we operate one of the nation's top children's hospitals, and are one of only nine hospital systems nationwide to receive the coveted Magnet designation.

Most would agree that an increase in the efficiency of the health care delivery system would go a long way toward an overall decrease in cost. Legislators, insurers, and hospital providers must work together to find new and innovative ways to address efficiency and the larger health care issues of access and affordability. I support efforts by the government to reward providers that are agile and innovative; that address accessibility in health care; that empower consumers; that stress preventive treatment; that focus their efforts on quality and transparency; and that invest in technologies that maximize medical and information efficiencies, eliminate redundant processes and procedures, and minimize errors in medical diagnostics and information management.

I believe very strongly that an emphasis on quality, transparency, and consumer empowerment in health care can reduce costs, thereby aiding the federal government as it struggles to ration scarce dollars and remain accountable to taxpayers.

I am here today to support the issue of developing greater price and quality transparency in the health care sector. Speaking as a consumer of healthcare, the technicalities of the hospital bill (technical fees) alone can leave one quite perplexed (redundant bills, inaccurate bills and statements titled "This is not a Bill"). Now add to that array of mail the bill(s) received from the physicians (professional fees), and you can understand the customer's need for price transparency from both the hospital and the physician.

A typical billing scenario:

A patient is diagnosed with lung cancer and comes to the hospital to have a biopsy performed. The patient will receive a bill from the hospital for the time spent in the OR, time spent in recovery, the anesthesia that was administered, and any ancillary services performed/items used while the patient was in the hospital (radiology exams, lab tests, drugs, supplies, etc.) The patient will also receive individual bills from the surgeon, the anesthesiologist, the pathologist, and the radiologist for the services they provided as part of the biopsy. In the worst case, each of the physicians and the hospital could have their billing handled by separate business offices. These business offices all have to gather the demographic and insurance information for their personal use, and independently code the diagnosis and procedure information for their specific billing. Some business offices will be more efficient than others in compiling this data and generating their invoice, and as a result the bills will be submitted to the insurance company/patient at different times. During the insurance billing process the patient will receive correspondence from each business office notifying the patient that "this is not a bill," but providing basic information on the services being billed to insurance. Once each bill is paid by insurance, the patient will receive a series of billing statements from each business office to collect on the co-pay/deductible amount. Depending on how quickly the insurance company processes the bills, the co-pay/deductible invoices will reach the patient at varying times. If different claim administration vendors process the Part-A and Part-B components of an insurance company's coverage (not a rare occurrence) the time until insurance pays for the hospital's and the physicians' claims could be very different. The pa-

tient will continue to receive regular statements (usually bi-weekly or monthly) from each physician and hospital business office until the invoices are paid. In this particular scenario the patient could receive 10–20 statements from as many as five business offices in the resolution of a single clinical occurrence.

Along with price, quality is the other major concern for health care consumers. While quality data is beginning to be standardized and disseminated to the public, it is not being displayed in an integrated manner with price information. It is a concern to Clarian that focusing on price alone treats health care as a commodity service rather than one with highly variable quality.

Clarian has already launched a quality website (www.clarian.org/quality) to aid consumers in their decisions, but it is our vision in the near future for Clarian to be able to quote our patients a price for a particular procedure *and* align that price with our quality data to give our customers a true picture of the value proposition for the services we provide. Our goal is to produce a predictable charging and pricing model for both inpatient and outpatient hospital services provided at Clarian, scaleable by weight (acuity of care and resources required). Our intent is to provide more than just price information so that we better support our customers' need to make a complete purchasing decision. "Here is what you're getting for your money."

From a billing perspective, a single case rate charge would be applied at the time of finalized coding, thus providing the patient with a much more simplified and easier to understand bill.

The model described above is achievable, but it is also fairly high risk to Clarian. The model should satisfy current public demand for improved access to pricing information but may also shift risk back to Clarian in regard to quality and efficiency of patient care. We are pushing forward with this endeavor because it is the right thing to do for our customers and for the health care industry.

It is our opinion that this model will not be truly used and useful to the customer until the health care industry is able to provide both the hospital's prices/quality data as well as the physicians' prices/quality data to the patient prior to services being delivered.

By empowering people to make decisions about their own health care, and by creating a transparent delivery system, we provide consumers with an incentive to become accountable and responsible health care purchasers. Consumers will reduce costs by seeking out and choosing qualified doctors and hospitals.

Consumers should demand and expect the same value proposition information (Value = Quality / Cost) from the health care market that they receive from other private sector businesses. When purchasing an automobile it is not knowing the price alone that entices most buyers (since many makes and models are of similar price) but knowing the safety and quality data. I would pay more for a car with a better safety record or pay more for a brand that has a good track record of not needing to be repaired all of the time. Personally, it is worth it to me to avoid the hassle of frequently bringing my car to the repair shop. Similarly, employers may be willing to pay more for higher health care quality outcomes for their employees. For example, employers may find it worthwhile to steer their employees to a high quality provider so that in the event their employee does need to be hospitalized, that provider has lower shorter of stay outcomes, thus enabling the employee to return to work faster.

Some employers are very active in this area by requiring preventive screenings. Thus far Clarian has encouraged our employees to participate in Health Risk Appraisals and through education and coaching we have directed employees to preventive care. Our health plans include preventive coverage. In next year's plan design recommendations we are introducing stronger economic incentives for healthy behaviors.

The Centers for Medicare and Medicaid Services (CMS) recently proposed a rule related to the fiscal year 2007 inpatient hospital prospective payment system. As a hospital system dedicated to transforming and improving the efficiency and quality of health care, we are pleased that CMS is working toward improving and refining the current diagnostic related groups (DRG) system. We believe it is critical that any refinements to the DRG methodology be accomplished in a manner that is transparent to all affected individuals and entities, and that any revised methodology be fully available in a timely manner to allow affected parties to comply. We will need immediate and unfettered access to information that will enable us to code and bill for inpatient hospital services. Transparency in this regard is equally essential to achieving quality and affordability in our nation's health care system.

Madam Chairman, we believe that there is a tremendous opportunity for change. We ask that Congress join us in our efforts to address rewarding those focused on providing transparency of quality and price by focusing additional federal resources on investments in technology and consumer-driven care, thereby enabling providers

such as Clarian to become more transparent, to empower their customers, and to work with other willing partners to reduce the costs associated with care.

Thank you very much for your time.

Chairman JOHNSON OF CONNECTICUT. Mr. Brenton.

STATEMENT OF STEPHEN BRENTON, PRESIDENT, WISCONSIN HOSPITAL ASSOCIATION, MADISON, WISCONSIN

Mr. BRENTON. Good morning. I am Steve Brenton, President of the Madison, Wisconsin-based Wisconsin Hospital Association. My written statement describes our initiative and also includes four screen shots taken off of our Web site.

As we grappled with the definition of transparency, our Association felt that it was all about important information needed to facilitate a better understanding about health care quality and health care costs and to provide help in facilitating purchaser decision making. We think that transparency is essential to facilitate enhanced health care literacy to facilitate provider accountability and consumer purchasing decisions.

Our PricePoint initiative is a key part of that larger transparency picture. Our initiative includes hospital-specific information about retail prices, about utilization, about payer mix and about charity and uncompensated care on a hospital-specific basis.

We believe that our PricePoint Web site and initiative is the most comprehensive statewide private sector initiative in the Nation. We are also working right now with seven other States to help them brand similar programs.

We also link our PricePoint initiative to our quality and safety Web site called CheckPoint, which is somewhat similar to the Hospital Compare Web site, although it does contain information above and beyond that nationwide Web site.

In the future, we intend to add high-volume out-patient procedures, we intend to facilitate better hospital comparisons, and we also intend to provide a consumer focus on hospital billing policies ideally by having a hospital-specific link where uninsured patients can access specific hospital billing guidelines.

We intend to do all of that or begin doing all of that within the next 12 months.

As we looked at the transparency issue—and my written testimony gets into this—we described three basic audiences that need the information; and our PricePoint initiative is designed to meet that public policy audience—the news media, lawmakers and regulators, and the curious public—by way of providing retail price information and the other financial and utilization data found on that Web site.

We believe that insured consumers with high-deductible health plans need to access information from the health plans that sold them those policies. Much as that is doing in Wisconsin, much as Humana is going to do, some other organizations need to step up and provide information to help purchasers know beforehand about potential out-of-pocket expenses associated with their health care coverage.

The third audience is the audience of uninsured. In Wisconsin, hospitals have pretty aggressive and proactive billing guidelines associated with the uninsured. I think we need to make those guidelines more transparent, and we intend to do that through our PricePoint initiative.

In conclusion, as we look at the pricing transparency issue, I think we are in the top of the second inning of what will be an extra inning ball game, and what is available today clearly is different than what should be available tomorrow.

Our organization is committed to growing and evolving our private initiative to make it more meaningful, but, overall, to be successful, we think that we need to have the engagement of providers and payers fully addressing the needs of the three audiences that I attempted to briefly describe.

Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Mr. Brenton follows:]

Statement of Stephen Brenton, President, Wisconsin Hospital Association, Madison, Wisconsin

Good morning.

I am Steve Brenton, president of the Wisconsin Hospital Association (WHA). WHA is a trade association representing all of Wisconsin's community hospitals and health systems, many of which are integrated delivery organizations that provide a continuum of services, employ physicians and own health plans.

Our association committed to a proactive price transparency initiative three years ago when Wisconsin's statutorily mandated hospital data collection program was transferred to WHA through a contract with the state. Under WHA's leadership, the program has been completely transformed and is now a reliable and timely consumer-focused information tool aimed at helping employers and employees make informed decisions about their health care.

The highlight of this effort is the interactive PricePoint (*www.wipricepoint.org)* Web site:

1) What is on the PricePoint Web site?

- Hospital-specific inpatient prices for all DRGs updated quarterly.
- Hospital-specific aggregate reduced prices taken by Medicare, Medicaid and commercial payers.
- Inpatient, service-specific utilization information.
- Hospital-specific annual charity care and uncompensated care totals.
- A link to hospital-specific quality and patient safety information.

2) Data Source for PricePoint.

- Hospital inpatient claims data submitted quarterly.
- Hospital-specific annual fiscal survey data.

3) Future Plans to Enhance PricePoint.

- High-volume outpatient procedures to be added by yearend and other outpatient services in the next phase (see slide with description)
- Web site reconfiguration to facilitate hospital comparisons.
- Consumer information to help patients navigate their way through the health care system.

A Leading National Initiative

We believe that today, PricePoint is the most comprehensive private-sector price transparency initiative in the nation. Our Information Center is currently working with seven states to brand similar programs. Our commitment to expand the amount of information and comparability of information will significantly enhance this price transparency initiative.

Audiences Requiring Price Transparency

1) **Public Policy**—The public policy audience, which includes the news media, legislators, regulators and the "interested" public, can best be served by providing timely access to "retail" charge information on inpatient and outpatient services and procedures. This is what PricePoint currently facilitates, including the provision of reduced price information by payer type in aggregate.

2) **Insured Consumers**—Insured consumers (shoppers) require timely access to information about potential out-of-pocket expenses to enable them to "shop" for elective services and procedures. This necessary information should be provided by the health plan that sold the policy to the insured consumer in order to facilitate purchase decisions.

3) **Uninsured Consumers**—Hospitalsshould be willing to counsel uninsured patients consistent with established billing and collection guidelines that should be transparent to these consumers. In June 2004, the WHA Board of Directors adopted guideline recommendations for hospitals that are widely in place in Wisconsin.

Conclusion

PricePoint is an important and significant pricing transparency initiative. Standing alone, however, our initiative is *not* the total answer to fully addressing the needs of the three audiences identified above. That's why we believe that health plans currently involved in marketing HSAs and high-deductible products must offer up information to their consumers as an essential, value-added service. Similarly, a focus totally on hospitals fails to generate necessary information from physician offices, freestanding diagnostic centers and pharmacies.

We also believe that informed consumers must have information about quality and patient safety to better understand their health care choices and decisions. That's why we also have made a commitment to a quality and safety measurement Web site . . . *http://wicheckpoint.org*. . . . .that facilitates and improves consumer literacy. The CheckPoint Web site is designed to align with and in fact stay one step ahead of the national initiative . . . Hospital Compare. Currently, *all* Wisconsin hospitals participate in our CheckPoint initiative.

WHA Information Center LLC

WHA Information Center **PricePoint** System

The Respected Source for Health Care Data

BASIC QUERY | COMPREHENSIVE QUERY | ABOUT | CONTACT | WHAIC HOME

St Francis Hospital
3237 S 16th St
Milwaukee, WI 53215
414-647-5662

Normal Newborn
October 1, 2004 - September 30, 2005

	Selected Hospital	All Hospitals in this County	All WI Hosp. with Similar Patient Volume	All WI Hospitals
Number of Discharges:	1,003	11,744	27,418	53,099
Average Length of Stay:	2.1 Day(s)	2.2 Day(s)	2.1 Day(s)	2.1 Day(s)
Average Charge:	$2,017	$2,155	$1,832	$1,713
Average Charge Per Day:	$942	$986	$861	$816
Median Charge:	$1,849	$1,855	$1,661	$1,575

NR = 1 - 4 Discharges (Not Reported)
= Show hospitals in that group

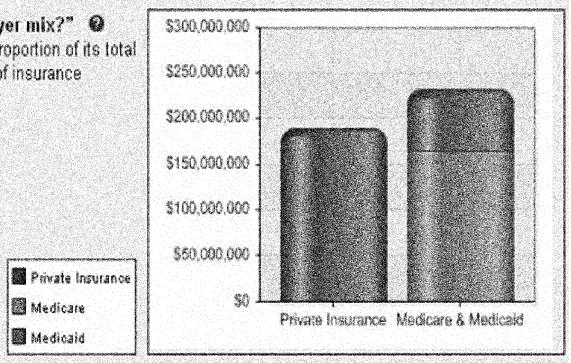
Notes About this Table
Understanding Facility Charge Information
Why Charges May Differ Between Facilities

View CheckPoint℠ Quality Reports for this Hospital

Select New Hospital | Select New Service at this Hospital

ST FRANCIS HOSPITAL
CHARGE AND PAYMENT INFORMATION
MOST RECENT FISCAL YEAR - ALL SERVICES

What is the selected hospital's "payer mix?"
A hospital's "payer mix" refers to the proportion of its total charges attributable to different types of insurance coverage.



How much do government programs pay compared to private insurance?
In many cases, Medicare & Medicaid reimburse hospitals at rates that do not cover the costs they incur to provide care. Payments from privately insured patients generally subsidize the shortfalls created by Medicare and Medicaid and therefore represent a "hidden tax" on individuals and families not covered by government programs. Click to view examples of Medicare & Medicaid reimbursement to hospitals in Wisconsin.

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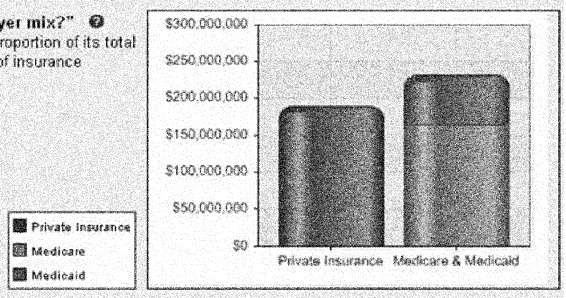

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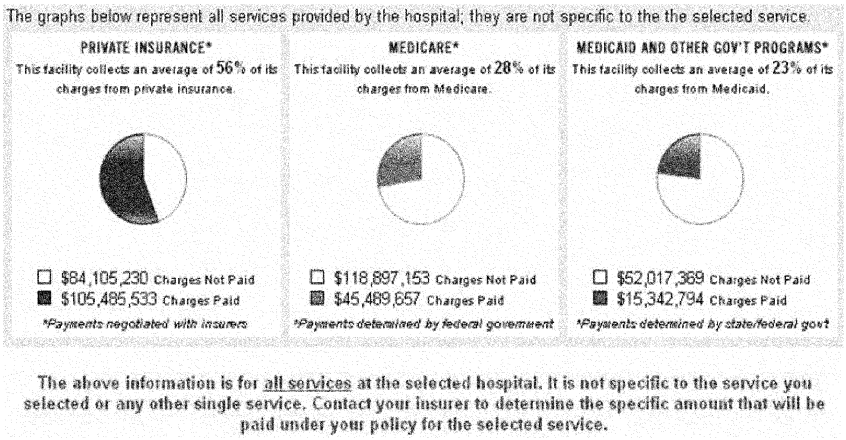

Chairman JOHNSON OF CONNECTICUT. Ms. Tu.

STATEMENT OF HA T. TU, SENIOR HEALTH RESEARCHER, CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Ms. TU. Good morning, Madam Chairman, Representative Stark and Members of the Subcommittee. Thank you for the invitation to testify.

My name the Ha Tu. I am a senior health researcher at the Center for Studying Health System Change, HSC. The HSC is an independent, nonpartisan health policy research organization funded principally by the Robert Wood Johnson Foundation and affiliated with Mathematical Policy Research.

With funding from the California HealthCare Foundation, HSC has conducted research on consumer shopping for health services, focusing on self-pay services such as LASIK. These self-pay markets are often held up as models for all health care markets. However, our research findings suggest that even for the simplest self-pay services there are important barriers to price and quality transparency and the extent of consumer shopping is quite limited.

That is a point I would like to briefly summarize, our findings related to LASIK. These findings are laid out in greater detail in my written testimony.

LASIK is a procedure that offers ideal conditions for price shopping for several reasons.

First, LASIK is an elective and nonurgent procedure so that consumers have the time and the ability to comparison shop. Second, consumers can gather initial price quotes for LASIK by phone at no cost and little inconvenience. In this respect, LASIK is unlike many other services that require in-person exams before any price quotes can be given. Finally, easy entry into this market by ophthalmologists has helped to encourage price competition.

Our research found that competition has helped to keep prices down in the LASIK market. The average price for the conventional LASIK procedure has declined by nearly 30 percent in the past decade after adjustment for inflation. However, this price decline has

been much less steep than a casual observer would expect, given the pervasive ads that most of us have seen for LASIK for $299. In fact, the average price of LASIK in the past year was about $2,000 per eye; and only about 3 percent of LASIK procedures actually cost less than a thousand dollars an eye.

We find that most consumers, in choosing a LASIK provider, rely heavily on word-of-mouth recommendation from previous patients. This is true of consumers in all price segments of the market. While consumers of premium-priced practices tend to focus on quality and consumers of discount-priced practices tend to focus on price, word of mouth is the primary way consumers choose the LASIK surgeon whatever the price segment of the market.

We identify three major challenges facing LASIK consumers.

First, LASIK providers don't package their services in any consistent way when they quote their fees to consumers; and, as a result of this, it is extremely difficult for consumers to make accurate apples-to-apples price comparisons across providers.

Second, some LASIK providers have engaged in misleading advertising by making price and quality claims that regulators have found to be unfounded. Both Federal and State regulators have taken action against misleading advertisers, but violations have persisted in this industry, and regulators acknowledge that they don't have the resources to monitor all of the violations.

The final challenge for LASIK shoppers is that substantial quality differences do exist across providers. There are large variations in how thoroughly providers screen patients, what kind of technology they use, and what their outcomes are, including success rates and complication rates. These variations are all evidence that LASIK is not a commodity, although it is often talked about as a commodity.

To summarize, we find there are barriers to price and quality transparency in the LASIK market, and these help to limit shopping.

When we turn to other self-pay services such as in-vitro fertilization, cosmetic rhinoplasty and dental crowns, we find even less shopping taking place in those markets because of additional barriers such as the cost and effort involved in getting price quotes, and in some IVF and dental crown cases, there is urgency involved which precludes comparison shopping.

Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Ms. Tu.

[The prepared statement of Ms. Tu follows:]

Statement of Ha T. Tu, Senior Health Researcher, Center for Studying Health System Change

Madame Chairman, Representative Stark and members of the Subcommittee, thank you for the invitation to testify. My name is Ha T. Tu, and I am a senior health researcher at 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.

HSC's main research tool is the Community Tracking Study, which consists of national surveys of households and physicians in 60 nationally representatives communities across the country and intensive site visits to 12 of these communities. We also monitor secondary data and general health system trends. Our goal is to pro-

vide members of Congress and other policy makers with high-quality, objective and timely research on developments in health care markets and their impact on people. Our various research and communication activities may be found on our Web site at *www.hschange.org*.

With funding from the California HealthCare Foundation, HSC has conducted research on consumer price shopping for health services, focusing both on self-pay services, such as LASIK, and analyzing the issue of price transparency for medical services that tend to be insured.[1]

My testimony today will focus on three key points:

- Consumers' experiences with markets for self-pay services, such as LASIK, are often held up as model for the entire health care system. Consumer shopping in self-pay markets has been mythologized with little investigation into how well these markets actually work for patients. Our research findings indicate self-pay markets are unlikely to be a workable model of effective shopping for health care services without either a large role for insurers or regulatory oversight.
- Insurers' buying power, or ability to negotiate significant discounts from hospitals, physicians and other providers, eclipses what patients can negotiate individually. And insurers potentially can become even more effective agents as they develop more sophisticated benefit structures and information tools to support consumers in choosing effective treatments from higher-quality, lower-cost providers.
- Encouraging greater consumer awareness about the costs of health services—i.e. consumer price shopping—does have potential to help contain costs without sacrificing quality—but some are overselling the magnitude of this potential.

SELF-PAY MARKETS

Whether they belong to conventional health plans with rising cost-sharing requirements or enroll in consumer-driven health plans with high deductibles and a spending account, consumers are facing more incentives to make cost-conscious decisions about medical services. Consumer-oriented approaches to health care emphasize price shopping as a tool for individual consumers to obtain better value and for the health system as a whole to curb rising costs and improve quality through increased competition. Until recently, most insured consumers have been sheltered from rising health care costs and have had few incentives to shop for the best deal. The extent to which consumers actually can become effective shoppers in the health care marketplace remains largely unexplored.

Self-pay markets in health care—those markets in which consumers largely pay out of pocket for services because of little or no insurance coverage—provide insights into how markets work when consumers must pay the total costs of services without the benefit of discounted rates negotiated by health plans or the restrictions of a provider network chosen by insuers.

Our research examines several self-pay markets in health care, focusing on one in particular—laser assisted in-situ keratomileusis (LASIK), a type of vision-correction surgery. LASIK was chosen for in-depth analysis largely because it is widely regarded as the self-pay market with the most favorable conditions for consumer shopping: it is an elective, non-urgent, simple procedure, giving consumers time and ability to shop; screening exams are not required to obtain initial price quotes, keeping the dollar and time costs of shopping reasonable; and easy entry of providers (ophthalmologists) into the market has stimulated competition and kept prices down.

While LASIK is a good procedure to evaluate for price shopping for these reasons, it is important to note that patients are rarely in a position to shop for completely elective, non-time-sensitive procedures, even if good price and quality information were available.

In addition to the in-depth look at LASIK, we've also examined other self-pay markets—in vitro fertilization (IVF), cosmetic rhinoplasty and dental crowns—to highlight how additional complexities and barriers to price and quality transparency affect consumer shopping behavior.

LASIK

Study Methodology. Initial research included a review of existing literature and news stories; informational material published by professional associations and gov-

[1] Two working papers from this project, "Shopping for Price in Medical Care," by Paul B. Ginsburg, and "How Consumers Shop for Health Care When They Pay Out of Pocket: Evidence From Selected Self-Pay Markets," by Ha Tu and Jessica H. May, are available by request by contacting HSC.

ernment regulators; and industry consultants' market reports. In addition, researchers reviewed online patient forums and examined LASIK providers' Web sites and print advertisements. Interviews included LASIK providers, industry consultants, laser equipment manufacturers, government regulators, and professional associations' management and senior staffs. Respondents were asked about the overall nature of the LASIK market—for example, to discuss price and quality information available to consumers and to describe typical consumer shopping behavior. Respondents also were asked specific questions based on their expertise and position in the market—for example, industry consultants discussed overall market trends and government regulators discussed misleading advertising and regulatory oversight of LASIK. In addition, the industry's professional association and a consulting company that specializes in providing LASIK price and volume data provided supplementary data on the LASIK market.

The Procedure. LASIK is an outpatient surgical procedure performed by an ophthalmologist that permanently reshapes corneal tissue to reduce light-refraction error and improve vision. A surgical blade creates a flap in the outer layer of the cornea. After the flap is folded back, a laser is used to reshape the underlying corneal tissue, and the flap is replaced. The surgery takes 10—15 minutes per eye, and the only anesthetic is an eye drop that numbs the eye's surface. LASIK was first performed in the United States in clinical trials in 1995.

Complications of LASIK include infection, dry eye, the flap failing to adhere correctly after surgery, less-than-perfect vision correction, and visual disturbances, such as seeing glare and halos, especially at night. Experts estimate that complications occur in 5 to 7 percent of all procedures. The complication rate has decreased over time with greater surgical experience and technological advances. The rate of severe complications, such as those that threaten long-term vision, is estimated to be less than.01 percent. In 5 to 18 percent of procedures, a second operation—called enhancement surgery—is needed to correct refractive error that was either not corrected in the first procedure or caused by the first procedure. The higher a patient's refractive error to start with, the greater the likelihood that enhancement surgery will be needed.

In the past few years, two new technologies have emerged in the LASIK industry. The first, custom wavefront-guided LASIK, uses wavefront technology to measure precisely how each eye refracts light and then guide the laser in customizing the corneal reshaping. Unlike conventional LASIK, custom LASIK can treat higher-order aberrations and is more likely to produce 20/20 or better vision and is less likely to result in visual distortions. Providers have widely adopted custom LASIK: 80 percent of providers now offer this technology, and the procedure accounted for nearly half of all LASIK procedures in 2005, according to MarketScope, LLC data.

The second refinement, blade-free or all-laser LASIK, involves the use of a laser instead of a surgical blade to create the corneal flap and is usually referred to as IntraLase. Many surgeons believe that IntraLase creates a more precise flap and results in fewer complications. Compared to custom LASIK, however, IntraLase market penetration has not been nearly as high: The technology was used in one in 10 LASIK procedures in 2005, according to MarketScope, LLC data.

Market Structure and Pricing. Market insiders describe the LASIK market as having three pricing tiers: discount, mid-priced and premium-priced providers. Discounters tend to market aggressively based on price. They typically handle a high volume of procedures, and patients often have little or no contact with the surgeon before or after surgery.

While discount providers are almost always high volume, experts note higher pricing does not necessarily equate to lower volume. What all premium providers tend to have in common is that they are surgeons whose credentials (such as research publications, affiliations with teaching hospitals and participation in clinical trials) enable them to command top dollar. Beyond this common trait, however, it is harder to generalize about these practices. Many premium providers run relatively low-volume LASIK practices that offer patients personalized care from the surgeon, both before and after surgery. Other premium-priced providers operate on a different business model: marketing themselves heavily, performing high volumes of LASIK procedures, and often relying on optometrists to conduct pre- and post-operative exams.

Many mid-priced providers are somewhat like the premium providers but without the top-notch credentials or surgical experience to command higher prices. Other mid-priced providers are large chains that may have started out as discount providers but moved to the mid-price segment through an emphasis on customer service, celebrity endorsements or other means.

In 2005 the price of LASIK averaged approximately $1,680 per eye for the conventional procedure and $2,030 for the custom procedure (see Exhibit 1). Premium-

priced providers currently charge about $2,200 per eye for conventional LASIK and $2,700–$2,800 for the most advanced technology (custom LASIK with IntraLase).

Although discount providers often advertise that LASIK is available for only a few hundred dollars, market experts note that the actual price of LASIK from a discounter averages $1,100–$1,200 per eye for the conventional procedure and $1,500–$1,600 per eye for custom LASIK, both with a surgical blade. (Most discounters have yet to adopt IntraLase technology.) This substantial discrepancy between actual and advertised prices exists largely because very few LASIK patients are medically eligible for the lowest prices. Indeed, it has been estimated that only 3 percent of LASIK procedures are performed for less than $1,000 per eye.[2]

In the decade that LASIK has been performed in the U.S., price and volume have fluctuated somewhat, but overall the average price for conventional LASIK has declined nearly 30 percent in inflation-adjusted terms. Two factors appear to be largely responsible for this market's price competitiveness: on the provider side, a large number of providers (ophthalmologists) can enter the market relatively easily; and on the consumer side, price quotes can be obtained at little cost and inconvenience. However, the decline in LASIK price is much less steep than what a casual observer might infer, given the pervasive advertisements of LASIK for only a few hundred dollars per eye.

There is no consistent bundling of LASIK services across providers. A high-end LASIK surgeon's fee might include a thorough screening exam, the procedure itself, and several post-operative exams, all conducted by the surgeon. If enhancement surgery is needed, a premium-priced surgeon might charge the patient nothing at all or only the procedure fee charged by the laser manufacturer. At the other extreme, some discount providers charge patients a nonrefundable fee for the screening exam, include little post-operative care and require full payment for enhancement surgery.

Information Available to Consumers. Reliable consumer information about LASIK is available from several sources, including the Federal Trade Commission (FTC) and the American Academy of Ophthalmology (AAO), which jointly produced a free consumer brochure, Basik Lasik.[3] This consumer resource discusses the procedure, its risks and possible complications; how to locate a surgeon; and what to expect before, during and after surgery. To help consumers find a surgeon, the AAO Web site lists all AAO members performing refractive surgery.

Basik Lasik and similar sources provide guidance to consumers on questions to ask of surgeons, but consumers still must gather this information from each provider. No centralized source is available for information such as number of procedures performed, success rates or enhancement rates for each surgeon, so consumers seeking to compare such quality-related measures across providers must invest considerable effort to gather this information.

Consumer Shopping Behavior. Although LASIK consumers are a heterogeneous group, the majority shares one trait, according to industry experts:Word-of-mouth recommendation from a previous LASIK patient is the most common way to select a LASIK surgeon. This holds true for all market segments, from discount to premium-priced providers. Practices that advertise heavily do draw many new patients through marketing efforts, but word-of-mouth still plays an important role—accounting for perhaps half of most discount providers' LASIK customers, according to industry observers.[4]

According to premium-priced surgeons, well over half of their patients tend to be focused on quality considerations. These patients are likely to ask prospective providers about LASIK technology, safety and outcomes, and a subset of these patients has done extensive research before contacting a provider. Among discount practices, not surprisingly, price tends to be the most important priority, and patients are much less inclined to focus on quality or to have done research. Industry experts estimate that perhaps one in five LASIK consumers overall—and a much larger proportion of discount providers' customers—tend to shop intensively for the lowest price (often by telephone) and base their purchasing decision solely on price.

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[2] David Harmon, MarketScope president, as quoted in: K. Garloch, "LASIK: Reward of Clear Vision Not Without Risk," *The Charlotte Observer,* January 18, 2004.

[3] Other reliable Web sources of information about LASIK include www.lasikinstitute.org (sponsored by the Eye Surgery Education Council, an initiative of the American Society for Cataract and Refractive Surgery) and www.usaeyes.org (sponsored by the Council for Refractive Surgery Quality Assurance).

[4] The different ways that consumers have of choosing LASIK providers are not mutually exclusive. For example, a consumer considering LASIK may see an advertisement promoting low prices, then talk to someone who had satisfactory surgery with that provider—which would reinforce that consumer's inclination to choose that provider.

In the LASIK market—in contrast to other self-pay markets—it is possible for a consumer to obtain telephone price quotes if they have their vision prescription.[5] An in-person exam is still needed, however, before the provider can assess the patient's eligibility for surgery, the likelihood of complications and the potential benefits of custom LASIK over conventional LASIK.

Consumer Satisfaction. Satisfaction rates among LASIK patients are high—about 90 percent industry-wide. Among premium-priced practices, especially those that emphasize careful screening and patient preparation, satisfaction rates can reach the high 90s. Even among high-volume discounters, some of which have received negative publicity for questionable business practices and some bad outcomes, satisfaction rates still appear to range in the 80s.

Issues Facing LASIK Consumers

Lack of Consistent Bundling. Because the package of services that are included in LASIK procedure fees varies across providers, consumers shopping in this market are confronted with "apples vs. oranges" comparisons. One critical factor when comparing providers' fees is to consider whether the provider includes the cost of enhancement surgery in the quote. A price quote that appears to be the best deal but does not cover follow-up operations may end up being the highest-cost option if enhancement surgery is needed. Whether thorough screening exams are included and how much post-operative care is included in the procedure fee also varies.

Misleading Advertising. Misleading advertisements have been a recurring problem with some LASIK providers, most notably discounters; federal and state regulators have taken action against some providers—and investigated many more—for making claims about price and quality that were found to be unwarranted.

In 2003, for instance, the FTC issued a consent order against LASIK Vision Institute (LVI) after finding that the national chain falsely claimed that consumers would receive a free consultation to determine their LASIK eligibility. Instead, consumers, after an initial meeting with a salesperson, were required to pay a $300 deposit before they could meet with an optometrist to be told of risks, possible complications and medical eligibility. If the consumer decided not to proceed with surgery, the entire deposit was nonrefundable. If the consumer chose to undergo surgery but was rejected for medical reasons, only a portion of the deposit was refunded. Although LVI signed an FTC consent decree, the practice of advertising but not providing a free screening has persisted in some markets. In November 2005, the Illinois Attorney General took action against LVI for this same violation, along with other misleading practices.

Advertisements run by discount providers touting very low LASIK prices are another important source of consumer misinformation. LVI, for example, runs advertisements promising "LASIK for $299." On LVI's Web site, the fine print states the offer is for surgery on one eye and applies only to those with no astigmatism and very low myopia, conditions that apply to a small portion of the LASIK patient base. Similar problems have occurred with print advertisements, leading at least two state attorneys general, in Illinois and Florida, to take action against LVI in 2005.

Consumers can be misled on quality issues as well by some advertisements. The 2003 FTC consent decree against LVI cited the provider for making unsubstantiated claims that LASIK would eliminate the need for glasses and contact lenses for life. Another national provider, LasikPlus, also was cited for making this claim, as well as additional unfounded claims that the procedure posed less risk to patients' eyes health than wearing glasses or contacts and that the procedure carried no risk of side effects.

In many cases questionable practices have persisted despite the settlements. And, regulators note that for the FTC to take official enforcement action against a provider, a practice must be "egregious" and "widespread;" they concede that consumers can also be misled by many questionable practices that fall short of these criteria. For example, local LASIK providers engaging in some of the same advertising practices as LVI would not be targets of FTC action, since their practices are not national in scope. Policing such providers generally would be left to state and local regulators, which vary greatly in the extent to which they enforce consumer protection.

Quality Issues. Many industry observers express concern that LASIK is regarded as a commodity by some consumers—leading them to shop only on price—when provider quality, in their opinion, varies considerably. Quality differences may be obscured by the fact that LASIK is relatively simple surgery with low complication rates, but for patients whose eyes have certain "problem" characteristics (e.g., abnormal topography, large pupils, thin corneas), quality differences may be critical.

[5] A prescription may not even be necessary to obtain a price quote, if the provider does not use tiered pricing based on strength of prescription.

Screening is the first step where provider quality differences matter: Industry insiders note that some providers—especially high-volume discount providers—may not adequately screen out patients who are not good LASIK candidates. When such patients are accepted for surgery, whether through revenue pressures or less-experienced or skilled screening staff, they suffer serious complications at much higher rates than average.

Investments in technology are another area where providers differ: The lower the price charged by providers, the less likely they are to use state-of-the-art technology that may provide better results. According to experts, the very low prices quoted by discount providers assume the use of older, less expensive laser technology that may produce an acceptable result (for example, 20/40 vision with visual aberrations) when a newer, more expensive technology might have produced a better outcome (better than 20/20 vision with no aberrations).

Poor quality outcomes, including severe pain, loss of best-corrected vision, or persistent double vision have been well documented in media accounts, online health forums and other sources. Such outcomes can result not only from poor screening but also from inadequate skill or experience from the surgeon, providing further evidence that LASIK is not a commodity and that quality differences can be substantial across providers.

Other Self-Pay Markets

While I have focused on the LASIK market, as I mentioned earlier, we also looked at self-pay markets for in vitro fertilization (IVF), cosmetic rhinoplasty and dental crowns. Consumers engage in little price shopping for IVF, rhinoplasty and dental crown services, according to experts in these markets. For IVF and rhinoplasty, most consumers choose providers based on previous patients' recommendations or physician referrals. For dental crowns, virtually all patients choose to stay with their regular dentist rather than shop around.

One important reason why shopping takes place so infrequently for these procedures is that accurate price quotes can only be obtained after undergoing in-person screening exams, since costs vary according to patient characteristics and medical needs as assessed by each provider. In some markets (cosmetic surgery) it is customary for some providers to offer free screenings, while in other markets (IVF and dental procedures), providers always charge for the exam. In the latter case, any potential benefit of identifying a low-cost provider would likely be negated by the costs of obtaining price quotes. But even when screenings are provided free of charge, consumers must still invest considerable effort in gathering price quotes.

Urgency is another factor precluding some consumers from shopping for IVF and dental crown services. Since one of the indications for a crown is that a portion of a tooth is missing, some patients may be in pain while shopping. Although IVF treatment may not qualify as medically urgent, industry experts note that consumers' sense of urgency about starting the procedure makes them unlikely to spend time price-shopping.

In the dental crown market, there are also important psychological barriers to shopping around. Surveys suggest that a large majority of consumers trust their own dentists, but at the same time, many express some fear or anxiety about major dental procedures. Thus, most consumers, when faced with the prospect of undergoing a major dental procedure, would be highly unlikely to switch from a regular provider they already know and trust to an unknown dentist solely to save on costs.

Implications for Price Shopping

Consumer-oriented approaches to health care sometimes focus on price shopping, without giving adequate priority to comparing quality across providers. Yet, widespread reliance on word-of-mouth recommendation in self-pay markets suggests that many consumers place a high priority on quality but may be using referrals from physicians or previous patients as a proxy for quality, given the absence of or shortcomings in concrete quality measures.

Concerns about quality disparities across providers appear to be warranted: Even for the relatively simple LASIK procedure—sometimes considered a commodity—quality differences across providers can be marked and can prove critical, particularly for the significant minority of consumers who have "problem" characteristics that put them at greater risk for complications or unsatisfactory outcomes. Consumers who consider only price when shopping for LASIK may end up with providers they would not have chosen if they had been aware of quality disparity issues. These consumers may not receive the best value for their money, even if they obtained the lowest price.

For consumers who do take quality into account when shopping, comparing quality across providers can be challenging. For LASIK, consumers must gather data on

success and re-operation rates from individual providers. Along with a need for centralized quality information, there is also a need to adjust outcomes data for patient mix—something not yet available in any of the self-pay markets we examined.

Educating consumers—providing information such as what credentials to look for in providers, how to compare prices and quality across providers, and what misleading claims to look out for—is essential if consumers are to act as their own agents in the marketplace. Government and professional associations can jointly take on consumer education, as they have done in the LASIK market. Monitoring of and enforcement against providers who engage in misleading advertising are also key elements of consumer protection. As the number and complexity of health care markets in which consumers are expected to shop on their own behalf expand, resources devoted to consumer protection will need to be increased substantially.

If all the tools discussed here were implemented, many consumers would benefit from improved price and quality transparency, but the benefits would not accrue to all consumers equally. Previous research has found that consumers with more education are much more inclined to seek health information on their own behalf,[6] so they are the most likely to benefit directly from any measures that improve price and quality transparency.

In applying lessons learned from self-pay markets to services covered by health insurance, it should be noted that many covered services are more urgent and more complex than the procedures we have analyzed—factors that would greatly reduce consumer inclination and ability to comparison shop. In addition, the fact that insurance will cover part of the cost reduces the financial incentive for the consumer to shop vigorously. Given that consumer shopping is not prevalent or active in most self-pay markets, we would expect the extent of shopping to be even more limited for many insured services.

ROLE OF INSURERS IN PRICE TRANSPARENCY

Moving from self-pay markets where consumers are responsible for paying the total bill to covered health care services, where consumers have less of a financial stake in care decisions, it's important to keep in mind the role of insurers. Much of the policy discussion about price transparency has neglected the important role that insurers play as agents for consumers and purchasers of health insurance in obtaining favorable prices from providers, as HSC President Paul B. Ginsburg, Ph.D., testified earlier this year before Congress.[7] Even though insurers have lost some clout in negotiating with providers in recent years, they still obtain sharply discounted prices from contracted providers.

Insurers are in a strong position to further support their enrollees who have significant financial incentives, especially those in consumer-driven products. Insurers have the ability to analyze complex data and present it to consumers as simple choices. For example, they can analyze data on costs and quality of care in a specialty and then offer their enrollees an incentive to choose providers in the high-performance network. Insurers also have the potential to innovate in benefit design to further support effective shopping by consumers, such as increasing cost sharing for services that are more discretionary and reducing cost sharing for services that research shows are highly effective.

Insurers certainly are motivated to support effective price shopping by their enrollees. Employers who are moving cautiously to offer consumer-driven plans want to choose products that offer useful tools to inform enrollees about provider price and quality. When enrollees become more sensitive to price differences among providers, this increases health plan bargaining power with providers. Negotiating lower rates further improves a health plan's competitive position. One thing that insurers could do that they are not doing today is to assist enrollees in making choices between network providers and those outside of the network by providing data on likely out-of-pocket costs for using non-network providers.

PRICE TRANSPARENCY CAN LEAD TO HIGHER PRICES IN SOME CASES

The Administration has recently been pushing hospitals and physicians to provide more information on prices to the public. If this is limited to prices paid by those

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[6] L. Baker et al., "Use of the Internet and E–Mail for Health Care Information: Results From a National Survey," *Journal of the American Medical Association,* Vol. 289, No. 18 (May 14, 2003). H.T. Tu and J.L. Hargraves, *Seeking Health Care Information: Consumers Still on the Sidelines,* Issue Brief No. 61, Center for Studying Health System Change, Washington, D.C. (March 2003).

[7] Statement of Paul B. Ginsburg, Ph.D., president, Center for Studying Health System Change, Consumer Price Shopping in Health Care, Before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Washington, D.C. (March 15, 2006).

who are not insured or those who are insured but are opting to use a non-network provider, additional price information for the public is may be a positive. But if hospitals and insurers are precluded from continuing their current practice of keeping their contracts confidential, this could damage the interests of those who pay for services, especially hospital care.

Antitrust authorities throughout the world have recognized that posting of contracted prices tends to lead to higher prices. In highly concentrated markets, posting of prices facilitates collusion. Even in the absence of collusion, posting would mean that a hospital offering an extra discount to an insurer would gain less market share because their competitors would seek to match it. Of course, this works on both the buying and selling side of the market, but if hospitals tend to be more concentrated than insurers, disclosure will raise rather than lower prices.

The experience in Denmark, where the government, in a misguided attempt to foster more competition in a concentrated market, posted contracted prices in the ready-mix concrete industry is instructive. Within six months of this policy change, prices increased by 15–20 percent, despite falling input prices.[8]

POTENTIAL FOR MORE EFFECTIVE PRICE SHOPPING

Unfortunately, much of the recent policy discussion about price transparency downplays the complexity of decisions about medical care and the dependence of consumers on physicians for guidance about what services are appropriate. It also ignores the role of health insurers as agents for consumers and purchasers in shopping for lower prices. Well-intentioned but ill-conceived policies to force extensive disclosure of contracts between managed care plans and providers may backfire by leading to higher prices.

We need to be realistic about the magnitudes of potential gains from more effective shopping by consumers. For one thing, a large portion of medical care may be beyond the reach of patient financial incentives. Most patients who are hospitalized will not be subject to the financial incentives of either a consumer-driven health plan or a more traditional plan with extensive patient cost sharing. They will have exceeded their annual deductible and often their maximum on out-of-pocket spending. Recall that in any year, 10 percent of people account for 70 percent of health spending.

When services are covered by health insurance, the value of price information to consumers depends a great deal on the type of benefit structure. For example, if the consumer has to pay $15 for a physician visit or $100 per day in the hospital, then information on the price for these services is not relevant. If the consumer pays 20 percent of the bill, price information is more relevant, but still the consumer gets only 20 percent of any savings from using lower-priced providers. And the savings to the consumer end once limits on out-of-pocket spending are reached.

In addition to those with the largest expenses not being subject to financial incentives, much care does not lend itself to effective shopping. Many patients' health care needs are too urgent to price shop. Some illnesses are so complex that significant diagnostic resources are needed before determining treatment alternatives. By this time, the patient is unlikely to consider shopping for a different provider.

Some of these constraints could be addressed by consumers' committing themselves, either formally or informally, to providers. Many consumers have chosen a primary care physician as their initial point of contact for medical problems that may arise, and choice of physician often drives choice of hospitals. Patients served by a multi-specialty group practice informally commit themselves to this group of specialists—and the hospitals that they practice in—as well. So shopping has been done in advance and can be applied to new medical problems that require urgent care. This is a key concept behind the high-performance networks that are being developed by some large insurers.

CONCLUSION

The need for consumers to compare prices of providers and treatment alternatives is increasing and has the potential to improve the value equation in health care. But we need to be realistic about the magnitude of the potential for improvement if consumers become more effective shoppers for health care.

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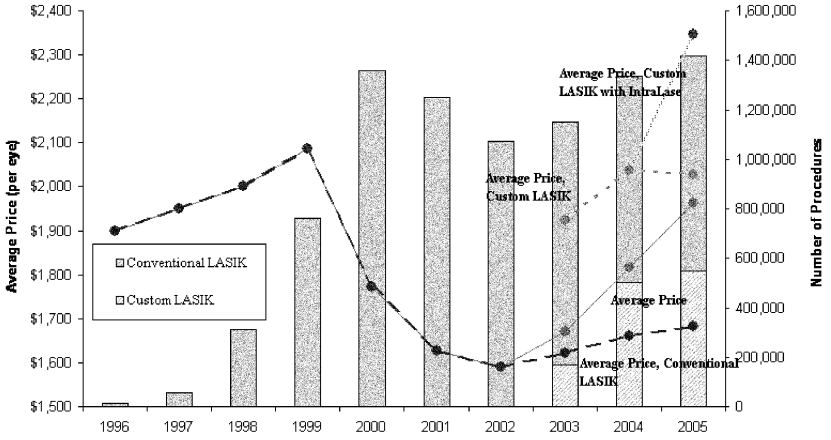
[8] Albaek, Svend, Peter Mollgaard, and Per B Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," Journal of Industrial Economics, Vol. 45 (1997): 429–43.

Exhibit 1. Average Prices and Number of LASIK Procedures in the U.S., 1996 through 2005



SOURCE: All price data and volume from Market Scope, LLC, excepting data on price prior to 1999 from SM2 consulting. Conventional and average prices for 2003, 2004 computed using Market Scope data. 2005 price data based on surveys from the first three quarters of 2005. 2005 volume data estimated for fourth quarter of 2005.

NOTE: In 2002, 1,000 custom LASIK procedures were performed (not shown due to chart scale). IntraLase price information available only for 2005 and majority of IntraLase procedures performed with custom LASIK, therefore average price with and without IntraLase only reported for custom LASIK.

Chairman JOHNSON OF CONNECTICUT. Let me just ask you, Mr. Brenton, my understanding of your tool is that you quote the average charges. Is that not as opposed to prices? You used prices in your testimony. On your example here you use the board average charge. Now we all know there is a difference between charges and prices.

Mr. BRENTON. Well, actually, there is a big difference between charges and what providers actually receive. I would argue that charges and prices are pretty much the same thing.

In order—but I think that what you are getting at is the charges alone aren't necessarily a good indication of what people are paying, what they would be expected to pay. I agree.

That is why one of the things we have tried to do on our Web site is to show this charge and then also to show PricePoint on average, in aggregate, what the Medicare Program pays based on charges, what the Medicaid program in Wisconsin pays and then on average what commercial payers are paying.

It is a way—it is a rudimentary way of demonstrating the issue that you are getting at.

Chairman JOHNSON OF CONNECTICUT. If you report what Medicaid pays, you are reporting an actual price that the State Government gives us for care of Medicaid patients. If you report the average of the prices that the private payers pay you, you are reporting an average price.

Mr. BRENTON. That's right.

Chairman JOHNSON OF CONNECTICUT. Both of those will be considerably lower than the charges?

Mr. BRENTON. In fact, our Web site shows that. It shows that on average, without question, the worst payer in Wisconsin is the Medicaid program; the second worst is Medicare; and then it shows that commercial payers quite frankly, it makes our advocacies that one of the reasons that charges are so high, one of the cost drivers associated with rising health care costs, is the failure of the Government programs to pay anywhere near—especially the Medicaid programs—the costs associated with providing that care.

Quite frankly, we thought it was innovative to have a Web site that actually shows or gives someone a taste of what, on average, commercial payers—what the average commercial discount is. I know of no other Web site in the country that begins to try to talk about that story.

Chairman JOHNSON OF CONNECTICUT. You do do that and very well. On average, where your individual prices for individual services, they are all about charges and not about prices; isn't that correct?

Mr. BRENTON. That's correct. It is because of the data tool that we use to run this Web site. We use administrative claims data which allows us to show a specific price for a specific in patient service, but we use an annual fiscal survey to get to that gross discount.

Chairman JOHNSON OF CONNECTICUT. I am conscious of my time, but I want to get to one bigger question for all of you. I want to ask Ms. Downey, you mentioned running focus groups in a pilot with our physicians. What were their major concerns and how did you meet them, briefly?

Ms. DOWNEY. Their biggest concern was that their patients would price shop and that they needed information on quality. We did the Cincinnati pilot it was really not for the consumer. It was really to see the physician reaction.

So, we already knew what the consumers were looking for. We wanted to engage and collaborate with the physician community to make sure we were going to be able to expect what we were going to be doing.

So, quality was the biggest piece, and some of the things like the tools said the negotiated rate. They said you don't negotiate with this. You tell us what you are going to pay, so don't use the word negotiated. We actually used CPT codes, which describe an office visit of 15 minutes or less, and that is the actual description. They said please take the time off. Since the patient is going to come into my office, they are going to look at your Web site and say, I get 15 minutes. You are asking me to leave in 10. So, I want my 5 minutes more. So, can you take that into consideration.

So, they gave us feedback like that. We incorporated all of that feedback in and as soon as the pilot was over and we knew that the physicians would work with us on that. When we got to our major release, which we just announced, we knew we wanted to incorporate the quality piece of it. So, that is going out with our next market so we could answer that.

Chairman JOHNSON OF CONNECTICUT. Let me ask both of you, the whole panel, about two questions raised by the Healthcare Financial Management Association discussion of this issue. I urge

your attention to it because it represents a lot of discussion among providers trying to think this through.

They make some recommendations, but clearly, at the beginning of the discussion, as you all pointed out, but they make two very important points. One is, patients need to know what the cost is going to be. So, I appreciate, Mr. Evans, Clarian's effort to accommodate the sort of severity of patient illness in estimating costs.

Clearly, if you go to the hospital, the hospital charges you, the doctor charges you, the anesthesiologist charges you, the lab charges you. So, there is a way and this is what interests me. There is a way that might be very fruitful to the whole system to look at preservice cost estimates, what the hospital is likely to charge you under these circumstances, given the rough cuts that we are capable of doing in today's world.

What would the anesthesiologist's bill likely be? What would the doctor's bill be? What would the tests likely be going to the doctor's office? What is the normal package of tests that goes along with an annual physical? Since the insurance company might not cover the test, only the office visit. So, I think we need to look at how do we give people a sense an integrated estimate of what their costs would be.

One of the things that this report demonstrates is, if you do a better job at the beginning, then all you have to do in the billing system is adjust that estimate for that particular patient's circumstances and need and what they actually consumed; and, therefore, it can lead to a far simpler billing. A lot of the basic information is input, every agent involved with that case has that information, and it will enable us to take great advantage of the health information technology system. We know that has to be there to service in the future.

So, instead of having a pyramid like this, where you know practically nothing price wise or cost wise or even what is going to be consumed and it all builds up and broadens out and you get all of these ridiculous bills because, remember, at the end, you never get an integrated bill that say this is the hospital's charges, this is the doc's, this is the labs' and so on. So, you never see the whole picture.

Having just gone through this with two family members, I can tell you I couldn't afford the hours it would have taken to figure out whether I was being charged correctly or not. I simply couldn't do that. It was worth it to me to just pay.

So, this is ridiculous. I am Chairman of the Committee, and I can't figure it out. So, integrated billing is one issue.

This second thing is the reference price method. In the hospital's price, Medicare pays me this price minus. Medicaid pays me this price minus. Private sector pays me this price plus. So, otherwise, we do have to or at least I would think—I am interested that Mr. Brenton does this. People have to see that Medicaid is shifting cost, that Medicare in some States is shifting costs and other States it is overpaying because of other cost shifters.

So, then, lastly, Dr. Herzlinger, throwing into this integrated pricing structure that we really need from the consumers' point of view and the variety of payers that we need to help people see how dishonest and chaotic this system is and why they are paying for

it, what gives you confidence that an SEC-type group will take on the interest and require prices, require private-sector prices as well as public-sector prices and so on when the system has protected its ethics extraordinarily well to this point?

Ms. HERZLINGER. Would you like me to respond?

Chairman JOHNSON OF CONNECTICUT. Yes.

Ms. HERZLINGER. The SEC did do it in 1934 when Franklin Delano Roosevelt got the SEC bills passed. There was no transparency, and he faced massive opposition from the business community. In fact, George Westinghouse, who was the head of the Westinghouse Company at the time, said, "Why don't you trust me? I am so palpably wonderful. Why do you insist on finding out what I actually earn."

Chairman JOHNSON OF CONNECTICUT. We have a different problem. We think we only have some that think only the Government can put out good pricing information that would be equitable and others your proposal is that the SEC in an objective manner can lay out the criteria. Measurement of quality is all over the place, and I don't know who I want to be able to

Ms. HERZLINGER. The SEC has a very good model; and that is the SEC does not, by and large, specify the measures, but it permits the Financial Accounting Standards Board, which is a broad-based coalition of experts who represent the diverse interest groups that are involved in our huge and very successful business community, to promulgate those standards. So, the Government is the iron fist in the velvet glove, but it is the private sector that comes up with the measurement standards, and it works.

Chairman JOHNSON OF CONNECTICUT. I think it is a very thoughtful proposal.

I would like the rest of you to comment on the idea of an independent body like SEC that would not only—as Ms. Tu pointed out—set the standard, but it would enforce them as well, but to this issue of integrated price and reference prices.

Mr. EVANS. I personally believe there needs to be a third leg in the stool, and either it is an SEC leg or regulatory leg. It is either negotiator or policy regulation pronouncements that can be relied upon to make us act in a more holistic way.

When I referred to this form, it is someplace buried in the regs that the doctors use and why they can't bill for an independent person. When I call Sears, they send the furnace guy out. I didn't know they worked for Sears.

That is overly simplistic. I understand that and trivialize the seriousness of this. In the last 5 minutes I am told the price of mammograms just went up at Clarian when the—if the patient wants to know what I said, is this any good. So, a diagnostic mammogram is 300 and some dollars and a mammogram is 146.

Now, what do you want? You want the diagnostic mammogram, and you want it now. If you have a thousand dollar deductible, the equipment that does the mammogram is generic. So, you can call around and get prices on the equipment, but what you want to know is the package.

I think the reason it took 500 years for accounting to morph into the SEC after the tulip crisis in Holland because it wasn't simple. This is the same thing. There are huge vested interests in the sta-

tus quo, and we are asking ourselves to take risks on the money end of it. You can bet that if our underwriters handicap our quality and transparency, we would change our practices, but they don't. It's not measured. What is measured is our day's cash on hand. That is what is measured. So, we will respond to what is measured as an industry.

Then I say to you and also to the study that you cited, how do you align the incentive so it crosses those silos? What Aetna's real-world experience told them that patients—the customer—reads the Web site. They didn't think they are being gypped out of 5 minutes of time. You know what the next question is? Can you give me one-third of the money I just paid you back?

So, the customer needs not only to be empowered but, as I said earlier, with used and useful data, not just a blizzard of data. I think we might want to use the instrument that was invented over 130 years ago, the telephone, so you can call, have a real conversation with a real person, describe your situation and get some rough idea, if not a pretty good idea, of what it is going to cost. Otherwise, we are going to have people at midnight on the Internet researching before they go the doctor's office at 7:00 a.m., and that is not——

Chairman JOHNSON OF CONNECTICUT. Ms. Downey.

Thank you that was very helpful.

Ms. DOWNEY. I think it is very complicated. Consumers have no idea. If you go to the outpatient or free-standing facility, you may be able to get a test for a procedure much cheaper than you can get at a hospital. So, they don't have any idea of that. They don't know that someone takes your films and someone else reads your films.

The average consumer on health care is very uneducated. It is a very sad state of affairs, but it should be one of the most important things. The average consumer doesn't want to take the time to do that. They don't want to make a phone call. You have to get to the consumers where they are, maybe Web site or mail. So, we have to get to them, and I think to have standards would be very appropriate.

I think we have to be careful about mandating so much that the health plans who are brandnew, trying to be very innovative and providing consumers with a lot of information, if they focus all of their time with trying to reach mandates so something gets presented in a certain way, you will lose all of the innovation in getting the information out.

I think there are if you look at 2 years ago, you wouldn't have a hearing like this. You wouldn't be having all of this conversation. This is an excellent thing to be able to do this, to be able to bring all of this out, and many parties have to participate in it.

Chairman JOHNSON OF CONNECTICUT. Mr. Brenton, did you——

Mr. BRENTON. I think she has made an excellent point. Although I personally believe that health plans, as opposed to the hospital business office or the clinic business office or the diagnostic center office, ought to be the one coordinating this billing estimate. I think mandates—I would not support mandates right now for the very issue or for the very reasons that were just outlined.

I think the health plans that do it well will flourish in the marketplace. We don't need mandates to regulate the success of those organizations; and I think over the next 2 or 3 years in fact you are going to see a lot of innovation in this area because of the need that this population has.

Chairman JOHNSON OF CONNECTICUT. Thank you very much.

Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Just a couple of questions. Then I want to come to a different solution.

Mr. Evans, Mr. Brenton, perhaps each of you could give me a range here, but if you took and I am just reading the benefit news chart if you took Aetna, Signa, Humana, Pacific Health Care you probably don't have United, WellPoint, which is now part of somebody else those payers, could you give me Mr. Evans, what is the widest range between the cost per procedure that those plans have been negotiated in your hospital? Five percent? Ten percent? How wide a variance in what you charge the different plans maybe through volumes or other reasons, what is the widest variations in percentage points?

Mr. EVANS. Among the commercial plants, it is pretty high—I am just guessing, Mr. Stark—5, 6 percent.

Mr. STARK. What would you say, Mr. Brenton?

Mr. BRENTON. I think in many ways it is higher. We have a more pluralistic 10 to 30 percent.

Mr. STARK. Thirty percent difference.

Mr. BRENTON. There can be, yes.

Mr. STARK. That would be the high would be the low-volume customers.

Mr. BRENTON. The lowest discount would be the low-volume customers, the ones that would have nothing to offer.

Mr. STARK. Ten percent as an average then.

Mr. BRENTON. Ten to fifteen percent.

Mr. STARK. Then let me ask Ms. Downey the reverse of the flip side of this. In a market—where do you see—what would you say is the widest range that Aetna can negotiate with hospitalwith a market with a lot of major hospitals? D.C.'s, for instance. What would be the range, would you guess, of the difference in prices that your plan could negotiate with hospitals?

Ms. DOWNEY. That is not my area of expertise, but I would say it probably could be if we have a lot of volume, their large plan sponsors there, then you could probably see a 15, 20 percent differential. You know, there could be, based on what we are able to bring to the table.

Mr. STARK. Maybe it is fair to say that somewhere between 5 and 15 percent is what the difference would be among major negotiators, major customers, if you will, who can direct business to your hospitals.

I guess what I am getting at is that as an old fan of the Maryland plan, and I am going to ask you just parenthetically, Ms. Downey, if you could separately send me a note or some idea of how you fare in Maryland where we have an all-payer system.

Dick Davidson negotiated—Ben Cardin, my colleague, was then in the Maryland State Senate Assembly; and it is a plan wherein every patient who walks through the door of a hospital pays the same rate. Their hospital-specific rates, which are negotiated by a public-private trust in Maryland and no hospital ever goes broke, they are designed—if you merge and take on another hospital, they give you a little higher rate. You are trying to start a separate, stand-alone specialty hospital. They ain't going to give you a higher rate. So, it may not be economic.

What I think I am getting to is that they have to come in on a 3-year average at 10 percent under the Medicare costs to get the Medicare waiver.

Think about that, guys. Ten percent under what Medicare pays in Wisconsin or Indiana, compared to your present rates now for Aetna. That means you couldn't bargain. If you went to Johns Hopkins, you would have to pay the same rate that everybody else, whether it was Humana or whomever.

Then in Maryland, as a consumer, I pick on quality. Since if I go to Hopkins, I am going to get the same rate that Aetna gets at Hopkins or Medicare gets at Hopkins or that the county pays for an indigent. That seems to me something I am more comfortable with. I am not getting gypped.

I know my brother-in-law did get a lower price on a car than I did because he could negotiate better with the salesman, and I feel like a schmuck because he got it for a thousand bucks less.

I go in. I know the rate is set. Hopkins fought this. They wouldn't have this any other way. So, I just commend that to you as a thought, because I think maybe doctors aren't going to like this plan any better.

I am suggesting that you are going to negotiate with somebody, whether it is Aetna, Mr. Evans, or whether it is Medicare, or whether it is whoever. Wouldn't you be as well off in your respective States—Wisconsin, Mr. Brentonif you chaired a group of both physicians, hospital executives, public policy people and you negotiated for each hospital so that the Day Marshal Clinic would get the same rate for everybody who came in in Milwaukee, but you know those hospitals were secure in providing care in their areas and they were getting a margin that would allow them to expand and grow and serve. Then I could pick—as a patient, based on the quality issues—I would go to U.S. News World Reports and find out where I should go or somebody else that I thought or my doctor who would give me the information.

So, as far as I am concerned, this would not be a Federal program. This could be State By State; it would then resolve many problems that the hospital industry worries about, and I think would go a long way.

So, Madam Chair, that is the Stark solution or some iteration of it. Well, I will take a second round. You have got a lot of——

Chairman JOHNSON OF CONNECTICUT. I think we should let the panel respond because you raised a very interesting issue, if you would care to.

Mr. BRENTON. Well, I am not an expert on the Maryland system. I know they have had a Federal waiver for 20 years, and I have a hard time believing they are getting the type of level of pay-

ments that we are getting in Wisconsin and running their excellent facilities and retaining docs in that kind of environment, so I would probably, first of all, have to be convinced that it is apples to apples.

Mr. STARK. Oh, I will get you—yes, it is.

Mr. BRENTON. If I went to Marshfield and told the physicians that they would be getting across the board——

Mr. STARK. No, not physicians, Mr. Brenton. This is only hospitals. The physicians fought it and stayed out.

Mr. BRENTON. Medicare payment in Wisconsin would create a hugely problematic problem with the—with our current marketplace in that our hospitals probably on average are getting about 85 percent of their costs through Medicare payment. So, it would create quite a series of issues as it relates to the current workforce and being able to

Mr. STARK. You as the head of this would set the rates so that each hospital would survive, and you wouldit would be hospital-specific rates. All you would have to do in the aggregate in Wisconsin is come in with your Medicare charges being 10 percent under the national average.

Mr. BRENTON. Well, I would certainly take a look at it.

Mr. STARK. Take a look at it.

Mr. BRENTON. There has to be reasons why other States haven't gone that route in the last 20 years. I think there probably are a unique set of circumstances that make it work in that State, and it does work in that State.

Chairman JOHNSON OF CONNECTICUT. Mr. McCrery.

Mr. MCCRERY. This is an excellent hearing, Madam Chair, and I commend you for putting this panel together.

Ms. Tu, your research indicates, as you note in your summary, that encouraging greater awareness about the costs or the health or the price of health services can indeed contain costs without sacrificing quality, but you say some oversell the magnitude of the potential for that. There probably are some who oversell that, and we certainly don't want to be guilty of overselling it, but on the other hand, we do not want to say—and you have said in your testimony—that there is no value in getting transparency in the costs and prices in the health care marketplace; is that right?

Ms. TU. Yes, that is right. Our research showed that having consumers free to shop and having consumers have the total financial incentive because they are paying completely out of pocket to the LASIK market has helped to keep prices down, but we also saw that prices are not as low as those advertised prices we have all seen on highway billboards and radio ads.

Mr. MCCRERY. The other element in overall cost is not just price, but it is utilization, isn't it?

Ms. TU. Yes.

Mr. MCCRERY. Well, you don't talk too much about consumers seeing the cost, the real cost, and choosing not to take advantage of some voluntary health procedure; is that right?

Ms. TU. Well, that is right. Since LASIK is a completely elective procedure, there are people who after looking at actual prices for LASIK——

Mr. MCCRERY. Decide.

Ms. TU. —decide they don't need the procedure.

Mr. MCCRERY. Right. So, the anecdotal evidence that we have heard even before this Committee and testimony, and we have read about in various news publications around the country of companies that are self-insured, for example, going to a high-deductible plan have saved or at least reduced tremendously the rate of increase and the cost of their plans; is that correct? Have you read those anecdotal reports of companies that have experienced those kinds of savings?

Ms. TU. Yes. With consumers who are in high-deductible plans and are responsible for most of the costs of their care. There are people who reduce their use because they have more at stake financially. In that situation, I think a lot of those services that are whose utilization is reduced is not directly comparable to LASIK

Mr. MCCRERY. Right.

Ms. TU. because there is appropriate use that is also reduced in some cases.

Mr. MCCRERY. Absolutely. Is there any evidence that the health outcomes in those cases have suffered?

Ms. TU. That is not an area of research that I have worked on, so I can't speak to that.

Mr. MCCRERY. Dr. Herzlinger, do you have any research on that?

Ms. HERZLINGER. I can cite the research on that. In fact, health outcomes have improved. Health care is 80/20; 20 percent of the people account for 80 percent of the cost, and they are typically chronically ill. One of the problems in management of chronic illness has been that people don't comply with their medication, but people who are in high-deductible plans, diabetics, asthmatics, they comply much more with their medication, and they have much more in the way of annual checkups. If we believe that that is good, then certainly health care outcomes will improve.

Mr. MCCRERY. Exactly. In fact, it should be counterintuitive that health outcomes go down if, in fact, the savings are real for the company or the plan, because as we know, if people avoid health care that is necessary for their health, they are going to wind up in the hospital in the emergency room, and that means the costs go up, not down.

Ms. Downey, you are with Aetna. I happen to have an Aetna HSA through the Federal Employees Health Benefits (FEHB) plan. This is my second year in your plan. I love it. Last year Aetna contributed $2,500 to my HSA, and I put in the other $2,500. This year you put in $3,000 in my HSA, so I only have to put in $2,000. Why is that? Why were you able to give $500 more in my HSA this year than last year? Do you have any idea? I know that is not your area of expertise, but maybe you have some hint.

Ms. DOWNEY. Well, I think if the costs and the utilization is not increasing at the same level as some other plans, then employers or plan sponsors have more money to be able to utilize to put into the HSA account on behalf of their employees.

We see large national employers who want to be able to do that for their employees. We also see that in studies that Aetna has done, studying the population that we have in both HRA and HSA plans, that, in fact, people are not getting less care; if you are a

diabetic, if you are an asthmatic, if you have cardiac conditions, you are still getting the same level of care that you got prior. So, we are actually looking at the experience of individuals who are in these consumer-directed plans, comparing it to when they were in HMO and PPO plans, and they are not having any deterioration of the services that they really needed. So, we are seeing that that is really happening, and we are seeing that when people have a stake in it, then they ask questions more than they did before, which is extremely important.

Mr. MCCRERY. Thank you very much.

Ms. HERZLINGER. They value it.

Mr. MCCRERY. Thank you, Madam Chair. Excellent panel.

Chairman JOHNSON OF CONNECTICUT. Mr. Camp.

Mr. CAMP. Thank you, Madam Chair. I agree, this is an excellent panel. I appreciate you all being here.

I still don't fully understand why we don't have integrated billing, why there is a lack of that. It is something that has been talked about for years, and we have all had anecdotally of us go to the hospital have an experience, seven bills come, and some are for $1.50, and some are from $2,000, and from people you never met or heard of or didn't even know were involved in the process. I guess I am looking at Mr. Evans. Please feel free to answer.

Mr. EVANS. I am going to try to make this short because it really is short. The reason you don't get a unified bill is because you didn't receive services from one vendor. You received services from many vendors who happen to have rooms in the same hotel. That is their only point of commonality. So, if you went in for surgery, the anesthesiologist, the surgeon, any extras they consulted with; let's say you had a stroke, a neurologist or a neurosurgeon, those are independent contractors. They do not work for Georgetown Medical University. So, you are going to get a separate bill from them, period, end of statement. That is the history of it.

Secondly, it is institutionalized in some rules and regulations. Corporations don't bill physician fees except in some specific exceptions because the corporations don't employ the physicians, so there is a separate form I referred to earlier, but you, the consumer/patient, go to the same hotel, right, and you order room service, all those sorts of things, and you don't see the differences between the two until you get this blizzard of paperwork.

What I can't figure out, and my colleagues can maybe comment on, what is the incentive to be separate? I see the incentive to be together. I don't see the incentive to be separate, other than what I call psychobabble, we all get to be independent and all that. I am a business guy. I think I can do a better job billing you if the people who run the various elevators in our hospital send you one bill, but I can't convince my colleagues of that. I can't convince every physician—we have a staff of 3,000—they would be better off. They want to bill you. They don't want the big mothership to bill you. So, that is why you get a half dozen bills. You have a half dozen different employers involved in that transaction.

Ms. DOWNEY. Can I comment on that?

Mr. CAMP. Yes.

Ms. DOWNEY. I would say that the question you just asked is, you are a consumer, and you are getting these bills now, and you

are seeing them. Before, behind the scenes, your health plan was taking care of doing all that, you weren't paying most of it, you really didn't care, but now all of a sudden it is paperwork, you are having to pay for it, you don't know what to pay, and I think you, as a consumer, just like all of us here, and the reason we are having all of these discussions, will begin to change that because you, as a consumer, will demand that this has to change. We are going to start to talk together and figure out how we make this better because it is in our best interest to make it better for the consumer.

Mr. CAMP. Yes. I wonder to what extent the rise of these boutique offices, where you actually have a physician who will manage the medical bureaucracy for you in terms of setting up appointments, billing—I know that in Florida and in some States these are pretty popular, and it is really an attempt to get at this compartmentalization that you describe. Why is that not catching on? I think it is in some areas, and among certain affluent folks, but that seems to me to be a real attempt to get around this because you almost need an advocate when you go into a large medical system just to wedge your way through it.

Yes, Doctor.

Ms. HERZLINGER. There is a wonderful physician in the State of Washington, Garrison Bliss, who is starting these are called concierge medicine.

Mr. CAMP. Yes, that is right.

Ms. HERZLINGER. I think it is a somewhat belittling term about their purpose, which is to integrate health care and make it better for the consumer. Garrison Bliss has a plan to provide concierge medicine for low-income and middle-income people at a cost per month of about $55. That is less than the average consumer pays for their automobile insurance. So, this is an industry in early stages and this is a very laudable attempt to make it available not just to wealthy people, but to low-income and middle-income Americans.

Mr. CAMP. Good. Thank you.

Thank you very much, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Camp.

Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chair.

I want to follow up. Mr. Brenton, you were given the opportunity to respond to Mr. Stark. In his interesting proposal regarding what sounded to me very much like a single-payer system actually, and wanted to give anybody else the chance Mr. Evans, any comment or thoughts as far as Mr. Stark? Or, Mr. Brenton, any follow-up?

Mr. BRENTON. Well, if—and again, my comments are based on experiences of working in West Virginia and Iowa and Wisconsin, not in Maryland. What works in Maryland very well may work well in Maryland. I am not sure that Wisconsin would ever get a Medicare waiver, and I guess despite the problems of the current system, I prefer the pluralism that is associated and innovation associated with having more than one payer. I think the success of HSAs and we, Wisconsin Hospital Association, have an HSA that is now 2 years old, and I am coming from a provider, not a payer, perspec-

tive. It has worked very, very well. We provide an annual physical on top of the HSA in order to deal with this issue of our employees not seeing a physician for a basic office visit to save money. We provide that on top. We have seen a significant anecdotal reduction in diagnostic testing, quite frankly, for things like a sprained knee playing tennis, and all of a sudden it is going to cost $800 as opposed to being free or $100.

You know, the skin in the game has an impact. So, I, despite—let me say it in a positive way. I think the innovation of having a variety of payers competing in the marketplace is preferable to a single-payer system.

Mr. HULSHOF. Dr. Herzlinger, you are nodding along. Do you want to chime in?

Ms. HERZLINGER. Well, I think generally economists think the problem with single-payer systems is that they stop price elasticity on the part of the consumers. That is, to the extent that the consumer is price-sensitive, and certainly since two-thirds of the uninsured are poor, they are highly price-sensitive, they would go to low-priced providers if there were price and quality data available, or the best value for the money kinds of providers. Having one price stops that kind of price elasticity and the rewards that accrue to the Toyotas in the health service business.

The other problem with a single-payer rate setting is setting the rate and I don't know that many entrepreneurs would be eager to join an industry where the Government sets the rates, because if they have a new way of providing services, they now have to persuade the Government bureaucracy to compensate to set up a rate category and compensate them freely for that.

So, those are the classic economist thinking about why single-payer kinds of environments in health care or elsewhere do not work.

Mr. HULSHOF. Mr. Evans, are you persuaded?

Mr. EVANS. Yes, well, it is—I have actually looked at the Maryland system because we don't view our competition as the hospitals up the street. We view our competition as an academic medical center, the 90th percentile on a qualitative measure of hospitals all over the country. So, Johns Hopkins and the University of Maryland we consider fertile recruiting grounds for staff and researchers, and we have hired Linda Malkas, the University of Maryland, and Keith Lillemoe from Johns Hopkins.

I am very familiar with their quality and their pricing structure. I wouldn't call it single payer in Maryland. I would call it a common method of negotiating. So, I have looked through Johns Hopkins, I have compared Johns Hopkins to us, and the big difference as far as I can see on the money end of it is the denominator is less from which they calculate discounts, because they don't need to go up like this and then start like the rest of us do because of this system. Whether at the end of the day it is any more rational in pricing to the end consumer is unclear. I have tried to find out in fact, I have family here, as you may know, and we use Johns Hopkins on a regular basis, University of Maryland, and the pricing doesn't appear to be a whole lot different than it is 565 miles away in Indianapolis for the high-end stuff, but what is different is the denominator. So, that is when you compare Johns Hopkins'

charges to the rest of the country, they look a whole lot less because they start out with a lower charge master, if you will.

Mr. HULSHOF. Ms. Downey, if the Chair will so——

Ms. DOWNEY. I think you also have to look at the efficiency. If you have transparency, it is not just consumer behavior that we are trying to change. We are also trying to change the behavior of the provider community. So, if you look at it, a very large multispecialty group in Seattle that has a hospital, and we were able to show them transparent data, how they compared to other facilities in their area and how they were much higher on low back pain, and looking at that and taking a very integrated approach, they were able to take out a lot of inefficiencies. What they ended up doing instead of giving everyone an MRI that came in, they ended up getting people to the physical therapist faster, they shortened their time of treatment by about a month, but they were making a lot of margin on the MRI.

What we ended up doing was starting to pay them more for physical therapy because they were losing money by not having people go in for the MRI. As a result, patient satisfaction went up, plan sponsors in the area were much happier because their patients their employees were now getting back to work faster, and they were able to do that with transparent data that we were able to provide to them so they could see how they compared to their peer group. So, there is a lot of inefficiency and it is not just a cost issue.

Mr. HULSHOF. Thank you.

Chairman JOHNSON OF CONNECTICUT. Mr. Ryan, a Member of the full Committee, not a Member of the Subcommittee, but a person who has been particularly interested in this issue, and I am glad he was able to join us.

Mr. RYAN. Thanks. A wannabe Member of the Subcommittee.

A lot of questions, but with the 5 minutes, Dr. Herzlinger, I want to explore the whole sort of SEC FASB model of price and quality transparency. You know, we are here in the top of the second inning of price and quality transparency, a long ways to go, and it is an extra inning with a nine-inning game, right, Steve, I think that is what you said. We are wrestling with should the Sovernment decide how to measure price quality? Should the Government decide how to measure quality metrics? We hear from the thoracic surgeons, we hear from the orthopedics, we hear from the cardiologists, we hear from the internists. Measure quality this way, measure it that way, do this this way, do it that way. We hear from this hospital it is this price, we hear from that hospital it is that price. Government, you figure it out.

My fear with that is, if we sit here in Ways and Means and try to come up with some mousetrap on how to measure these things, then we will miss the market, and it will be clumsy and dictatorial and bureaucratic. So, how do we have some kind of objective, recognized third-party system that everyone recognizes, it is what it is; this is an apple, and that is an apple, and it sticks with the market? How does your idea on a FASB-like model handle that? Could you explain that idea a little bit further?

Ms. HERZLINGER. Certainly. Thank you for the question, Congressman.

The FASB is a collection of the important interest groups in the business, so it represents the business community, the chief financial officers of business, academics, professionals, the accountants themselves, and they have a broadly consensual, completely open decisionmaking on how to measure certain issues. It is a process that, while not perfect, has made the American capital markets the best in the world.

The SEC has the right to measure how businesses do, but from the beginning, Franklin Delano Roosevelt gave up that right, and he called the SEC, said the appropriate role for Government is to make sure the truth is told. He called it the truth agency. If the Government is the promulgator of the truth, in addition to all the difficulties you mentioned so eloquently, it also loses the inability to audit whether the truth has been told. You can't be both the truth teller and the auditor of the quality of that truth.

So, I think the FASB in this particular case is a very effective partnership, and we know it is so because our capital markets were so efficient and widely emulated throughout the world.

Mr. RYAN. So, FASB is the truth teller, and SEC is the truth auditor?

Ms. HERZLINGER. Great way to put it. It also says if you don't tell the truth, I am going to really punish you. The SEC is essentially a profit center, and it is a profit center because of the huge fines that it collects from people who don't tell the truth.

Mr. RYAN. Mr. Evans and Mr. Brenton, Steve, I have known you a long time. We talked about the PricePoint Website many, many times. It is charges plus some kind of a universal discount that is an average discount. So, I have always believed that the PricePoint is a good first step in probably a five- or six-step process that Wisconsin Hospital Association is going to have to go through to put real paid prices for this hospital, for that hospital, for this hospital. If you took Tom Barrett and myself—Tom was a former Member, Democrat from Milwaukee, took 3 years to get the GAO to do a study on prices in health care, and that was just using older data from the FEHB model. We did this hearing in Milwaukee where we found that the price paid private payers in just Milwaukee actually ranges from for a bypass surgery from $47,000 to $160,000—$140,000 in just the metro area, which is about a 10-square-mile area. So, we have found quite a difference in prices actually paid.

What I want to ask the two of you, the hospital guys, is tell me a little bit about hospital politics. Tell me a little bit about how difficult it is to get each hospital to be willing to publish their prices, the prices paid. Are some hospitals cutting-edge, willing to submit it? Are other hospitals, heck no, we won't go, and therefore you go to the lowest common denominator and you put charges up? Tell me a little about that.

Mr. EVANS. Ambiguity breeds fear, and if they are not clear, hospital executives are going to be afraid. They are going to think prices will go down, not up. They will cut programs, cut services, lose their jobs, everything bad you can imagine.

The range you just described, of course, can be dependent upon three or four pretty significant variables, not only the payola, but the health status of the individual. So, I can't really respond to that except to say it is probably true.

Seems to me—and this is very pie in the sky—that hospital executives and associations are running essential public services, and the rules ought to be a little different with respect to competition than they are on things that aren't essential public service. I hate to analogize to this, but the best I can think of is public utilities where we have actually screwed things up by over regulating, and we find foreign businesses buying U.S. businesses. I don't want to take that analogy too far.

There needs to be the rule maker and the truth teller, and the truth will be what are the quality standards, and the rules would be, well, what are the rules if you futz with the quality standards and overcharge somebody for what they bought? We have robust rules in this country for a violation of a Consumer Product Safety Act, 1974, I think, on this very issue.

So, I wouldn't mind as a hospital executive a few more rules about transparency, but right now the antitrust rules are what stop us. I go to a meeting in Wisconsin with my competitors, we cannot, will not discuss price, cannot. In fact, lawyers will start the meeting by giving us the normal discourse. So, right now the rules are, can't collaborate on price, period. So, the only people that know price are the payers. That is, they know what they are paying the different providers, and they are competitors, too. So, right now the system doesn't seek to squeeze those prices together. It seeks to do just the opposite.

Mr. BRENTON. Well, what a great answer. I have very little to add other than, it may not be a bad idea, Congressman Ryan, to have the FEHBs publish those negotiated prices in their markets. Now, we quickly point out that in much of Wisconsin, there aren't a lot of Federal employees, and the Blue Cross PPO doesn't have much leverage in markets like La Crosse and Green Bay, and those are market forces that go into play relative to the negotiations. It might be a good place to start because your earlier question was, should Government decide or what should Government do, and from my perspective, Medicare as a purchaser in the FEHBs a purchaser can play a role, should play a role.

When it comes, though, to Government as a regulator, I have got a little bit more of a concern than I do as Government as a purchaser. When you look at what CMS has done on the quality and the safety front and its commitment to do more over time, we have got a good start there. When it comes to prices, it is a more complicated ballgame. Maybe Government could start by publishing those negotiated rates with hospitals and physicians that have contracts with that FEHB agency.

Mr. RYAN. Do you think Medicare ought to release its 100 percent file in a Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104–191) compliant way, just release all the Medicare claims data so the public can see it?

Mr. BRENTON. I have no concerns whatsoever with Medicare releasing its claims data in a transparent we may have to help the public understand what is in that file, but, yes, I think that is fine.

Mr. RYAN. Great.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. Stark has some additional questions he would like to pose.

Mr. STARK. Well, Madam Chair, we have been on the hospital issue. I just wanted to add to my friend from Missouri, the Maryland plan is an all-payer plan, not a single-payer plan, and it means that there are many, many different payers, but each hospital has a different set of rates set by a public/private board so the hospital survives. As far as entrepreneurship and quality, Johns Hopkins still remains the best hospital in the United States. So, in Maryland, they have been able to have the highest quality institution insofar as we know.

However, I wanted to come back. You know, we have been talking about the hospitals all day being transparent. If I am an Aetna beneficiary, then can I find out which hospital has the lowest cost as a member?

Ms. DOWNEY. Today not a hospital, because we focused on physician first because we felt——

Mr. STARK. Do you intend to do that?

Ms. DOWNEY. We intend to next year begin to move into the——

Mr. STARK. Let's say I am going to have a baby this year, and I am choosing——

Chairman JOHNSON OF CONNECTICUT. Theoretical.

Mr. STARK. Does Johns Hopkins take care of that?

As a prospective customer, are you willing to make public the different rates that you have with different hospitals?

Ms. DOWNEY. For 2007, we are going to be discussing what it is we are going to do from a hospital standpoint.

Mr. STARK. Well, that is not exactly the issue I was looking for. I am not sure other—in other words, I am asking Mr. Evans to tell me. If I want to choose we have got 9 million members of the FEHB, and let's say that we are going to buy a high-deductible plan. I think it is the dumbest thing in the world, but if we buy one, we buy one; therefore it becomes important if you are planning a pregnancy to know what each plan's price at Sibley or George Washington is, right, so I know what plan to sign up for for the year, because with a high deductible plan, I am arguably going to be out of pocket 1,000 bucks or more.

Now my guess is that the plans are not so willing to tell me prospectively what their negotiated rates are because I imagine they feel that would put them in a competitive problem because then Len Schaeffer, God forbid, would be able to see what you have negotiated with Mr. Evans, and he is a little scumbag who will cheat you, and so you want to watch out. You don't want to let Len Schaeffer know what you negotiated with Mr. Evans. So, is it going to be comfortable for you to make public——

Ms. DOWNEY. Well, we did it for physicians. We are the only ones who have done it with physicians, and they told us we were crazy to have done it.

Mr. STARK. Only for subscribers.

Ms. DOWNEY. What we are going to do for hospitals will only be for subscribers.

Mr. STARK. That is what I am getting at. How do I know when I am trying to buy a plan? I am not negotiating with hospitals. I am buying the plan.

Ms. DOWNEY. You as a Member eligible for the Federal employee plan would be able to at your enrollment time would be able to have a guest ID to be able to go in and look at that information.

Mr. STARK. Okay. Even if I am not a member of Aetna, if I have the Blue Cross, and I got the reenrollment period, I can go in and see what your charges are and compare them to Blue Cross.

Ms. DOWNEY. Since your employer is part of our health plan. We have to be able to provide that information.

Mr. STARK. In the individual market, that wouldn't necessarily be available.

Ms. DOWNEY. Not today as an individual. That doesn't mean it wouldn't be in the future, but that doesn't mean not today.

Mr. STARK. I guess what I am getting at, we have focused on the hospitals here, but with 80 percent of Americans having health insurance, we are not apt to go to a hospital for which you won't pay the bill.

Ms. DOWNEY. Correct.

Mr. STARK. That doesn't make much sense for any of us. So, our limitation is not so much on what Mr. Evans is charging, but it is whether you or Blue Cross or Humana has negotiated a deal with Mr. Evans so I could go there and get the bill paid.

Ms. DOWNEY. Right. The important thing to know is what we will reimburse you. So, we will next year provide ranges to be negotiated.

Mr. STARK. I guess all I am saying, Mr. Brenton, is your members are dealing with some pretty big buyers. I don't know who the big ones are in Wisconsin, but whomever they are, they are not just dealing with, well, Golden Rule doesn't negotiate with anybody. They, I understand, don't make this information and I suspect it is because they don't have enough clout in the market, but in any—yes, it is a small market, but in Wisconsin and I guess I would say, it doesn't have to be Medicare.

If we could resolve this, we are talking about 5 or 10 percent spread, maybe 15, except for the marginal purchasers, and what we failed to understand is that when you have these rates, like the Maryland rate, you get that money for everybody who comes through the door. That means the counties, or the State if it is Medicaid, is paying your hospital, Mr. Evans, so that, the 10 percent below Medicare is the aggregate, and if you are collecting your bills and not having to send these guys out with their Doberman pinschers to collect the bad debts, my guess is your revenue is going to be substantial enough to make up for it. You are going to deal with some large bureaucracy, whether it is Ms. Downey is arguably nicer than CMS, but you are going to end up in your business your members, Mr. Brenton, you are not going to escape this.

I am just trying to suggest that if we could put the hospital guys to rest and as consumers just be sure that, whether it is Dr. Herzlinger 's idea of an SEC, that we are getting the best rate in each hospital so that I don't have to worry—you are not going to like this, Ms. Downey—but if I am going to go to Mr. Evan's hospital, I don't really care then whether I have Blue Cross or your insurance. I know there is a negotiated rate. Then I want to look at his record. I want to see if he is going to be transparent on the times he has been sued or been charged with malpractice, and how

many people have come out of the hospital feet first. Those are issues that are a little bit more important to me. So, that I want to see the transparency in the quality almost more than I do the price, because my price was negotiated with Ms. Downey on a monthly premium, and I didn't translate that through to something that I don't anticipate, albeit maybe the pregnancy.

So, I think, Madam Chair, if we could get the hospitals just to set a standard so that and then we have got to go to the docs and the prescription guys where we are going to where we have more variation, because I don't—I don't know even if I got on the Internet that I would know where to go to shop because I would end up going to my doctor or to my Aetna list, and they would say, here is your choice. Aetna maybe has a broad choice as, say, Blue Cross does.

So, while I want the transparency, I think I want some help because I don't know where to begin. Mr. Evans isn't sure what to tell me because of all these bills from the anesthesiologist, radiologist and all the other guys.

One more. Mr. Evans, you paid $500,000, $600,000 to radiologists, a bunch of them. I saw that on your report. Do you bill for those guys, or do they bill, you collect?

Mr. EVANS. We own the radiology function. The radiologists work for a separate not-for-profit corporation. So, technically, they are a vendor. This is how perverse it is. We are the sole member of the 501(c)(3).

Mr. STARK. Okay.

Mr. EVANS. So, even though we are the sole member of the 501(c)(3), it is a separate corporation. So, I am in a bit of an arm-wrestling match right now with our CFO.

Mr. STARK. If they had worked for you, then you would have to be like a Pfizer.

Mr. EVANS. If Hopkins had a clinic model, it would be easier to bill in a uniform way.

Mr. STARK. Mr. Brenton doesn't know this, but I am old enough to have known Dr. Doege. That dates me with the Marshfield Clinic. How do you like that?

Madam Chair, thank you. I could talk with you.

Ms. Tu, I just wanted to say, I hope we read her testimony as showing that if there are out there in the market just being able to shop and get a lot of information, we still may get gypped, which may make the SEC or FCC or whatever more necessary. The reason she picked the LASIK is there is no insurance payment, I don't think, and it is an elective thing you would decide on price, and even there people aren't getting the best price when they have the so-called transparency, so that we move ahead at our risk.

I want to thank the witnesses for suffering through all of this again with us, and look forward to more hearings on this, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Thank you. Thank you.

I would like to make a couple of conclusions. First of all, Ms. Downey, I appreciate Aetna's leadership on price transparency with physicians, and, Mr. Evans and Mr. Brenton, I really appreciate your work, trying to tackle this issue in the hospital setting. Ms.

Tu, you make the point that is very, very valid. You can't compare prices if they are apples and oranges, and we have to make sure that if we compare prices, that the prices include the same bundle of services.

That kind of brings us back to Dr. Herzlinger. If FASB is the truth teller because they set the accounting rules, what we have currently in Government is a bureaucracy that has been unable over decades to set uniform standards as to what the cost reports ought to report. Now, this is so basic, it is sort of startling, but that is where we are. Then on top of no standards, just about allocating costs uniformly in reports the Government receives in order to set Medicare prices, so look at the depth of this failure.

It is not that they didn't know, because this Committee had hearings 3 years ago on how we tried to get to uniform reporting so that we could have timely data. So, this has not been an issue that we haven't asked for GAO reports on and so on and so forth. We have not been able to solve the problem of how we get providers to report costs in a timely fashion so we can set public policy validly.

Secondly, that cost report system is complemented by a body of law that then tells us how we will set wages in the formula and how we will adapt them regionally. That system is working so poorly that in the MMA we arbitrarily threw $900 million at the program and said, scrap for it, dogs. One of those dogs got it in my district, and one didn't. Twenty minutes apart, urban hospitals, roughly the same book of business, $6 million difference in payment.

You would never, ever get that if there was any FASB-type rules underneath this system. Look at the physician payment system. Completely unworkable if you let it happen. We will cut physician payments 5 percent a year for 6 years, and we will have no doctors serving Medicare patients.

So, not only have we been unable to do the simple thing of uniform rules for cost reports, but the law undergirding every other payment system is literally collapsing. For years we have given the nursing homes extra money because we are so under-reimbursing them under Medicaid.

So, this issue of price transparency and how do we go about reporting it, identifying it, is extraordinarily important. I hope all of you, including Ms. Downey, Aetna, will look at this issue of what is the price not just to see the doctor, but the likely tests you are going to have or the likely medications. We don't have to go too far down that path, but we do need to look at what is the—when you look at it holistically and integrated, we need to have hospitals be able to understand what is their costs, what is the doctor's cost, what is the anesthesiologist's costs.

We do have, I want to point out to you, two things that are going on relevant to what we are doing, because I want you to think about it and feel free to be able to provide input. Game-sharing. We have a game-sharing pilot that overcomes this whole issue of part A and Part B and will allow an integrated billing and will allow everyone to understand what the total costs of a hospital stay and procedure are. We might need to make some extra effort to encour-

age those game-sharing demonstrations to adopt a new billing system and help show us the way.

Then we have a home office demonstration project that we are working on that would be the equivalent of boutique of concierge what did Steve call it? Or one of you, I guess Regina, you called it concierge medicine. If we don't have a kind of medical home that can coordinate for people with chronic illnesses, particularly of low-income or elderly, then we can't possibly make any real effort at preventive care or care management, and we have no shot then at reducing costs.

So, there are experiments out there that should help you go to the next step. You might want to apply to be part of those experiments because you are coming at this with so much additional experience and information. We aren't in just a little trouble, we are in vast trouble, and if we don't solve it, Medicare will solve it, and they will solve it like Medicaid solved it. They will just under-reimburse you, and under-reimburse you, and under-reimburse you. This is what the Canadian system has done. This is what other systems have done.

So, it is not mysterious what will happen if we don't rise to the challenge, but price transparency is one piece, along with quality reporting and others, that we must be able to do accurately and intelligently, but we must never mislead patients to believe that their choice of medical care should depend entirely on price because it must not, and it cannot if they are going to have the quality care that we know is available in America.

Thank you very much not just for being here, but for your leadership as thinkers and doers in the health care arena. I appreciate it. Thank you. The hearing is adjourned.

[Whereupon, at 11:59 a.m., the hearing was adjourned.]

[Submission for the record follows:]

Statement of American College of Physicians

The American College of Physicians (ACP)—representing 120,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. ACP is pleased to share its recommendations with the Subcommittee on how best to guide consumers' choice of physician through price transparency.

In the first section of this statement, ACP discusses the potential advantages that price transparency offers to patients. In the second section, ACP offers recommendations on what is realistic *at this point in time* in terms of disclosing fee information to patients. The third section discusses the obstacles inherent to transparent physician price information.Finally, due to ACP's concern that price, alone, is a poor proxy for determining the total cost of care and informing consumers' choice of physician, ACP recommends that Congress look beyond the disclosure of unit pricing and consider new payment models that provide consumers with a more meaningful picture of a physician's performance.

For definitions of terms often used in the context of this discussion, please refer to **Appendix A.**

I. ACP's Support for Transparency

ACP is committed to the goal of transparency for health care pricing. For years, ACP has encouraged its members to discuss with patients the fees charged for their services—in advance of rendering services, whenever possible—with the qualification that the fee charged for an office visit or other service does not necessarily predict the *total* cost of care. ACP also recently developed a policy monograph on consumer-directed health plans, which pointed out that consumers must be provided with accurate, accessible, and understandable information in order to make well-informed health care decisions. This position statement calls on employers, health in-

surers, and regulators to make sure that valid and reliable information and appropriate decision-support tools are made available to consumers. It also states that public policy and private sector responses are needed to guide the development of standardized measurement, data collection and dissemination, and decision-support tools to assist consumers to navigate an increasingly consumer-oriented health care system.

II. Recommendations on What is Realistic at This Point in Time

The following subsections make recommendations on how price information could be disclosed on a voluntary basis and in a user-friendly manner to the following groups: Medicare patients; patients with typical managed care or PPO plans; and self-pay patients.

Medicare Beneficiaries

ACP believes that public access to physician pricing for Medicare patients can best be achieved by modifying the publicly accessible physician fee schedule database(s) available through www.cms.hhs.gov. Medicare pricing for physicians that participate in the program is currently accessible in a format that is understandable to industry professionals, but not to patients. This system would have to be modified and available through a website maintained for Medicare patients, such as www.medicare.gov. To make the website patient-friendly, ACP recommends the following:

- Patient first enters zip code;
- Patient has the option to view all prices for physician services for his or her Medicare geographic-adjusted area or to search by specific physician service/procedure;
- The prices should be displayed in the following format:
  - Lay person description of service/procedure;
  - Current Procedural Terminology (CPT) code;
  - Medicare allowable amount, with typical Medicare payment (80 percent) and typical patient co-payment (20 percent);
  - Medicare limiting charge amount, which pertains to unassigned claims submitted by non-participating physicians, with typical Medicare payment (75 percent of Medicare allowable) and typical patient co-payment (difference between 115 percent limiting charge and 75 percent of Medicare allowable);
  - Indicate if the service is Medicare non-covered, i.e. never covered by Medicare regardless of the patient's condition, with a statement that physicians can charge the patient their established fee even if it is more than the Medicare allowable.

While this information would not differ from one physician to another within a Medicare geographic adjustment area, it would enable patients to compare Medicare prices to physician retail prices and to amounts paid by private insurers, if available.

Patients Enrolled in Managed Care or PPO Plans

While Medicare generally pays a single amount for each service (adjusted slightly by geographic area) to all physicians, patients in managed care or PPO plans need to be informed about the discounted rates that health plan members actually pay, since the maximum allowable payments are determined by the provider's contract with the insurer. The out-of-pocket cost to patients enrolled in managed care or PPO plans for a specific service or procedure is the co-pay or co-insurance for covered benefits or the retail price for non-covered benefits that the patient elects to receive.

To best inform a consumer's choice of provider, private insurers must make consumers aware of the actual negotiated rates it pays its physicians for individual services. Information about what an insurer will reimburse is currently available to the consumer retrospectively, or after care has been received, and often only at the request of a member. ACP recommends that this information be made available prospectivelyso that the consumer can make a well-informed decision. Insurers should work with physicians to determine the actual out-of-pocket cost to the consumer and to determine how best to present this information.

ACP recommends that the Administration review private sector initiatives for guidance on how best to provide consumers with price information (see **Appendix B**).

Self-Pay Patients

To give self-pay patients access to physician charges, ACP could recommend that its members make their retail price public for the 10 services/procedures most commonly furnished by the specialty of general internal medicine (using Medicare na-

tional aggregate billing data) or for the 10 services/procedures they personally furnish most often by posting the information on their website, if applicable, and/or disseminating it on patient request. ACP prepared a template that could be shared with our members for use by those who choose to make their retail prices widely available (see **Appendix C**).

CMS could also make this information available through its publicly accessible Participating Physician Directory (PPD), which enables patients to identify physicians who participate with Medicare. The PPD is currently available through www.medicare.gov/physician. In 2003, CMS proposed that physicians have access to their individual PPD record so that they could self-report whether they are accepting new patients. CMS could expand the PPD to include physician self-reported prices for non-Medicare patients. CMS likely would want to house this modified PPD database elsewhere, such as on the U.S. Department of Health and Human Services website, since the prices would reflect the physician's retail prices and be irrelevant to Medicare. CMS should provide a template that physicians could use to report their prices.

Further, ACP believes that CMS could expand the modified PPD that contains physician prices to include additional information on services that a patient may find valuable. Physicians could self-report information such as whether they maintain an in-office laboratory; whether they accept Medicaid as a secondary payer; whether they provide minor clinical services via e-mail; and whether they provide transportation services. Physician self-reporting of this additional information should be voluntary. This information could supplement physician-specific quality data and would likely be easier for the patient to understand.

Although the actual amount that a physician charges is most valuable to patients who pay for services out-of-pocket (including those with indemnity or high-deductible health plans), patients with other insurance products—such as Medicare or a private HMO—may also find this information valuable to compare what their insurance pays toward the physician's retail price.

III. Obstacles to Transparency

Although ACP offers these short-term strategies, we remain concerned about the complexity of providing patients with the information and decision-support tools they need in health care. Introducing transparency into the medical marketplace depends on a convoluted set of circumstances and challenges, each of which hinder the effectiveness of some or all of the aforementioned strategies:

- Physician fees for a specific service or procedure have little relationship to the total cost of care. Knowing how much an internist charges for a "typical" office visit, for instance, does not tell the patient anything about what level of office visit may be required, what tests or procedures may have to be ordered, or what other costs could be incurred for referrals to other physicians or health care facilities.
- The costs associated with an entire episode of care would be a more relevant indicator—but such cost of care measures are still very much in their infancy. To be meaningful, those measures would have to encompass the services of multiple providers and sites of service, as well as pharmaceutical, radiological, and laboratory costs, rather than just the cost of care provided by a single physician.
- Physicians often have a single retail "fee" for each service, but the amount they charge—and the amount they actually collect from the patient—is a function of a specific contract signed with a particular insurer.
- Some physicians practice in more than one setting or in the employment of more than one employer, so an individual physician may have a different set of fees for each setting and/or employer, meaning the physician may have multiple fees for the same service.
- Telling patients what a physician's retail fees are for common procedures still does not let patients know what they will have to pay out-of-pocket—unless insurers also disclose how much they reimburse for a given service, including the patient's co-pay or co-insurance for covered services, in advance.
- The fees physicians can charge and the amount they can collect from patients enrolled in Medicare, the country's single largest health care payer, are subject to strict price controls.
- Comparing prices could be misleading unless patients also have comparative data on the quality of care provided. However, we are still very much in the early stages of developing physician-specific, evidence-based quality measures that can be reported to the public.
- And finally, there is little evidence to date that patients are willing or able to consider the price of services when seeking medical care for themselves or family members, particularly for non-elective, urgent or potentially life-threatening

illnesses. To the extent that patients would consider price, experts are concerned that patients may forgo beneficial treatments.

For these reasons, price transparency is most useful for elective procedures where the patient has the time and ability to potentially choose among different providers. But even in such cases, price may still not be a good predictor for the total cost of care and any posting of the typical fees for elective procedures needs to state this clearly.

IV. Recommendations on Looking Beyond the Disclosure of Unit Pricing and Considering New Models

ACP is concerned that price data, alone, is a poor proxy for determining the total cost of care and informing consumers' choice of physician. As long as Medicare and other payers continue to pay physicians based on unit prices and volume of services, efforts to introduce price transparency will have only a limited impact on quality, cost, and consumer decision-making. We therefore recommend that the Administration look beyond the disclosure of unit pricing and consider better ways to help patients make informed choices.

New payment models proposed by ACP would provide consumers with a more meaningful picture of a physician's performance by reflecting quality, cost, and patient experience, while at the same time incentivizing physicians to organize their practices to produce better care at a lower cost. Providing consumers with more robust data on both cost and quality is the premise behind ACP's recently proposed Advanced Medical Home (AMH), a patient-centered, physician guided model of health care under which patients would select a physician based on service attributes—such as patient-centeredness, improved access, and coordinated care of a practice—as well as value attributes as demonstrated by publicly available reports on quality and cost. ACP believes this model would provide consumers with a much more comprehensive and complete assessment of a physician.

ACP also supports the concept of linking payments to physician performance on evidence-based measures. The College's position paper, "Linking Physician Payments to Quality Care," provides a framework for developing and implementing a Medicare pay-for-performance program that would recognize and support the value of care coordination and quality improvement by a patients' physician. Incentives would be based on effort, so that physicians who expend a disproportionately large amount of time and resources trying to improve quality—such as the effective management of patients with multiple chronic diseases—are recognized and rewarded accordingly. This is especially critical for the internist, whose ability to provide better care at lower costs through effective management of patients has been historically under-valued.

ACP's long-standing commitment to evidence-based medicine and continuous quality improvement is also evidenced by our active involvement in the Ambulatory Care Quality Alliance (AQA). The AQA, a national consortium of large employers, public and private payers, and physician groups, aims to improve health care quality and promote transparency and uniformity by evaluating ways to most effectively and efficiently measure physician performance, aggregate data, and report on the results. The AQA recently endorsed principles on: reporting to consumer and purchasers; reporting to physicians and hospitals; data sharing and aggregation; and efficiency meaures. It is also pilot testing quality reporting at the physician practice level.

More information on these topics can be found at:

- The Advanced Medical Home:
  http://www.acponline.org/hpp/adv_med.pdf
- Linking Physician Payments to Quality Care:
  http://www.acponline.org/hpp/link_pay.pdf
- The Ambulatory Care Quality Alliance:
  http://www.ambulatoryqualityalliance.org/

ACP welcomes the opportunity to meet with you or your staff to further discuss these topics.

Conclusion

Any model for price transparency must take into account the special circumstances involved in patients' medical decision-making and the peculiar way that health care is financed in the U.S. It is also critical that transparency models be created specifically for and by those who deliver and receive health care services, rather than being grafted onto medicine from another industry.

ACP is committed to working toward the goal of transparency in pricing and quality and appreciates the Administration seeking our input on how best to inform consumer decision-making in health care. We hope this discussion will encourage the Administration to look beyond unit pricing of physician services and to consider alternative models that would make the overall quality and efficiency of health care transparent to consumers.

Appendix A

Definition of Terms Used in the Context of Health Care Pricing Transparency

- *Retail price:* refers to the amount charged for a service and is most relevant to self-pay patients (e.g., those who do not have health insurance or have a high-deductible health plan) and traditional indemnity insurance patients.
- *Cost of care:* refers to the total cost of services provided to a patient (price multiplied by volume and intensity of services). Cost of care can be accounted for at the level of an individual physician based on the costs for which the physician is directly responsible or can include the costs of care associated with all the care received by a patient for a specific episode of care.
- *Total cost of care measures:* refers to measures of the total cost of care attributable to a given provider for a defined episode of care (by diagnoses and duration of services provided).
- *Allowable amount or maximum negotiated fee schedule amount* (or other similar terms): refers to the amount that a health plan will reimburse for a particular service, which may have little or no relationship to the retail price charged by the provider.
- *Out-of-pocket expenses:* refers to the costs for which the patient is responsible; the amount of patient out-of-pocket expenses varies according to whether the patient has Medicare; is covered by a typical managed care or PPO plan; or is self-pay.

Appendix B

Private Sector Initiatives

Aetna: Recently became the first health insurer to make available online the actual negotiated rates it pays some of its physicians for their services. Aetna posts the actual discounted rates it pays doctors for about 25 of their most common office-based procedures, such as physicals, electrocardiograms, and vaccinations. Under an initial pilot program, members in the greater Cincinnati area can now look up the fees charged by 5,000 local physicians and specialists.

Cigna: Uses a three-star rating system to rank hospitals by their contracted rates for specific services. The insurer soon plans to replace the stars with actual price ranges. Cigna also recently launched a web-based tool that lets members comparison-shop for medications at 52,000 pharmacies nationwide. Enrollees can view the discounted price of drugs at various pharmacies as well as their share of the total cost based on the type of coverage they have.

Humana: Provides members with an online tool that lets members compare hospitals based on their average discounted price for an entire episode of care. The price quotes are derived from claims data Humana tracks by diagnosis. The prices reflect inpatient costs as well as physician fees, laboratory work and all other expenses related to a specific procedure. By entering their ZIP codes and the type of care sought, members can view estimated out-of-pocket costs at up to 10 local hospitals at a time.[1]

Council for Affordable Quality Healthcare (CAQH): CAQH, which represents many of the nation's largest private health plans, has an initiative to establish a system that provides physicians with online access to patient eligibility and benefits information for CAQH participating health plans. The goal is to give physicians access to patient eligibility and benefits information before or at the time of service. Physicians would be able to send an on-line inquiry from a single point of entry, using an electronic system of their choice (similar to the real-time response from processing a credit card charge), to find out:

- Which health plan covers the patient;
- Whether the service rendered is a covered benefit, including co-payments, co-insurance levels, and base deductible levels;
- What amount the patient owes for the service; and
- What amount the health plan will pay for the authorized service.

[1] Benko L. Price Check! Modern Healthcare. November 14, 2005.

ACP recommends that the Administration contact CAQH to determine if it is interested in exploring whether this initiative can be modified to provide payment information specific to a particular physician within a specific health plan.

Appendix C

Common Services/Procedures Pricing Template

[X Internal Medicine Practice] believes that patients have the right to know what the charges for physician work might be before arriving at the office. We have posted the fees for our ten most common services/procedures below. Please note that it is often difficult to determine what must be done to find out what is wrong with you or how to take care of it until you arrive in the office. For that reason, we cannot say with certainty how much care you will need from us or from others, such as the lab or a pharmacy, and how much you will be charged in order to diagnose and treat your condition.

These charges are the established fees for the office and in most cases do not match the amount that the patient will pay. The amount paid by the patient will vary based on insurance coverage and the meeting of deductibles and copays. It is also important to remember that your primary goal in seeing a physician and our primary goal in treating patients is the maintenance and improvement of health and our practice is fully dedicated to this goal.

Service	Price	Medical Code*
Office Visit (New Patient)	$xx—$xxx	99201–99205
Office Visit (Established Patient)	$xx—$xxx	99211–99215
Hospital Admission	$xxx—$xxx	99221–99223
Hospital Visit	$xx—$xxx	99231–99223
Hospital Discharge	$xx—$xx	99238–99239
Nursing Home Visit	$xx—$xxx	99231–99233
Electrocardiogram (EKG)	$xx	93000
Flu vaccine	$xx—$xx	90655–90658
Chest X–Ray	$xx—$xx	71010–71030
Removal of Lesions	$xx—$xxx	17000–17250

*These codes are needed for insurance companies to process bills.

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