WHAT'S THE COST?: PROPOSALS TO PROVIDE CONSUMERS WITH BETTER INFORMATION ABOUT HEALTHCARE SERVICE COSTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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HOUSE OF REPRESENTATIVES

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WHAT'S THE COST?: PROPOSALS TO PROVIDE CONSUMERS WITH BETTER INFORMATION ABOUT HEALTHCARE SERVICE COSTS

WEDNESDAY, MARCH 15, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Nathan Deal (chairman) presiding.

Members present: Representatives Bilirakis, Shimkus, Pitts, Bono, Burgess, Barton (ex officio), Brown, Waxman, Pallone, Green, Capps, Allen, Baldwin, Dingell (ex officio), and Deal.

Staff present: Chuck Clapton, Chief Counsel for Health; Melissa Bartlett, Counsel; Ryan Long, Counsel; Nandan Kenkeremath, Counsel; Bill O'Brien, Legislative Analyst; David Rosenfeld, Counsel; Brandon Clark, Policy Coordinator; Chad Grant, Legislative Clerk; John Ford, Minority Counsel; Chris Knauer, Minority Investigator; Purvee Kempf, Minority Counsel; Amy Hall, Minority Professional Staff Member; Bridgett Taylor, Minority Professional Staff Member; Jessica McNiece, Minority Research Assistant; and Jonathan Brater, Minority Staff Assistant.

MR. DEAL. We will welcome our guests to our members of our distinguished panel this morning and some are not here and will be joining us hopefully before the opening statements are concluded.

I recognize myself at this time for an opening statement.

Certainly, I think all of us are concerned with the subject that is the text for the hearing today and that is how to best increase the level of transparency in our health care delivery system. We all know that in order for markets to function properly, consumers must have information about the goods and services they are purchasing, and the health care market is no exception to that rule. Each year, Americans spend over $2 trillion on their health care, which accounts for 16 percent of our annual gross domestic product. Despite the unmountable importance of these purchasing decisions, it is virtually impossible for the average American

consumer to find any quality or pricing information about health care providers. This situation is unacceptable and I hope will soon change.

American consumers have the right to choose their health care providers and these consumers deserve to know pricing and quality information about these providers so that they can make the right decisions. No one purchases a car without first gathering information on the prices and quality of the different available models. Why should health care be any different? If one hospital charges several thousand dollars more for the same procedure, shouldn't the consumer have access to this information? If I am paying for it, out of my own pocket, I would like to know that. If one surgeon is significantly more successful at performing a certain procedure than another surgeon, shouldn't the consumer have access to this information as well? If it is a member of your family or if it is you, I think all of us would agree we would like to know that.

At a recent visit to one of the largest hospitals in my congressional district, the administrator stated that one of their biggest concerns was that 90 percent of their self pay patients, which are mainly patients without health insurance, never paid for any of the services they received. Well, in some ways that is not surprising given the fact that we really know that these people are asked to pay some two to four times as much as those patients with similar procedures who have health insurance. It simply doesn't make any sense to charge people that cannot afford health insurance or choose to pay for some procedures out of pocket much more for the same procedure. The uninsured deserve to know what prices they are going to pay. I believe that if these patients had access to meaningful and understandable pricing and quality information, providers would no longer be able to get away with this kind of injustice. As we have seen in so many other areas, empowered consumers increase the level of quality when driving out inefficiencies and waste. It is my hope that we can do the same thing in health care.

Again, I want to welcome our witnesses and at this time, I would recognize my friend from California, Mr. Waxman, for an opening statement.

[The prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON HEALTH

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- I am proud to say that we have a very distinguished and expert panel of witnesses appearing before us today that will help us explore how to best increase the level of transparency in our healthcare delivery system.

- We all know that in order for markets to function properly, consumers must have information about the goods and services that they are purchasing, and the healthcare market is no exception to this rule.
- Each year, Americans spend over $2 trillion on their healthcare, which accounts for 16% of our annual Gross Domestic Product.
- Despite the undeniable importance of these purchasing decisions, it is virtually impossible for the average American consumer to find any quality or pricing information about healthcare providers.
- This situation is unacceptable and must change.
- American consumers have the right to choose their healthcare providers, and these consumers deserve to know pricing and quality information about these providers so that they can make the right decision.
- No one purchases a car without first gathering information on the prices and quality of the different available models.
- Why should healthcare be any different?
- If one hospital charges several thousand dollars more for the same procedure, shouldn't the consumer have access to this information?
    - If I'm paying for it out of my own pocket, I know I would like to know.
- If one surgeon is significantly more successful at performing a certain procedure than another surgeon, shouldn't the consumer have access to this information?
    - If it's my son or daughter having this procedure done, I know I would like to know
- At a recent visit to one of the largest hospitals in my district, an administrator stated that one of their biggest concerns was that 90% of their "self-pay" patients, which are mainly patients without health insurance, never paid for the services they received.
- Of course, this isn't too surprising given the fact that self-pay patients are often forced to pay between 2 and 4 times more for the same procedure than a patient with health insurance.
- It simply doesn't make any sense to charge people that cannot afford health insurance or choose to pay for some procedures out-of-pocket so much more for the same procedure.
- The uninsured deserve to know what prices they are going to pay, and I believe that if these patients had access to meaningful and understandable pricing and quality information, providers would no longer be able to get away with this injustice.
- As we have seen in so many other areas, empowered consumers increased the level of quality while driving out inefficiencies and waste.
- And it is my hope that we can do the same thing for healthcare.
- Again, I welcome our witnesses and thank them for their participation.
- I now recognize my friend from Ohio, Mr. Brown, for five minutes for his opening statement.

MR. WAXMAN. Mr. Chairman, since Mr. Brown may yet arrive would you give me the three minutes rather than five minutes?

MR. DEAL. Certainly.

MR. WAXMAN. This hearing is a worthwhile one to have. Transparency in prices is good. In some cases, particularly in the area of drug prices, it can be a benefit to the consumer. But no one should think

that the topic we are addressing today comes to grips with the serious issues facing our health care system. Transparency in prices doesn't provide health insurance coverage for the nearly 46 million Americans that are uninsured in this country today. Transparency in prices is no substitute for real coverage. Transparency in prices doesn't give the individual the ability to negotiate in any effective way. Individuals need the negotiating power of a group to secure good prices. Employer sponsored group health insurance can negotiate meaningful discounts, individuals cannot.

And transparency in prices does not make them lower. We only need to look at the recent reports of the pricing policy of Genentech for its cancer drug Avastan. Why the $100,000 price and dramatic increase this year? Because a manufacturer decided it could get away with it. That is the reason, pure and simple. So transparency of price is not going to help that woman with breast cancer or the man dying of lung cancer. This is the kind of cost that won't be effectively addressed unless someone who has strong negotiating power enters the picture.

It is ironic that this Republican Congress turned its back on giving the Secretary of HHS the authority to use the negotiating power of 40 million Medicare beneficiaries to get lower drug prices. And it is equally ironic that the actual deals and rebates that the private insurance plans are negotiating with the drug companies are not made available to the public. Instead, we get a list of prices that can be changed by the plans at any point.

So that just points out several concerns that we have got to keep in mind when we hear of the value of transparency in prices. It is no substitute for real negotiation. What benefit it can provide is limited. It only helps if it is accurate, does not change, and is in useable form. It does not help if the information is so voluminous and confusing that the average person cannot use it. It does not help if it is not related in a meaningful way to quality measures. And it certainly does not help if it is really an excuse to justify putting more of the burden of the costs of the health care system on the individual. High deductible health plans are exactly the wrong answer when people need affordable coverage. Putting the individual out there on his own to negotiate better deals from the health care system is exactly contrary to what works.

So I welcome transparency in prices so long as we all understand that is an approach that offers some slight advantage at the margin but it should never be confused with an answer to the real problems of the high costs of health care and of the millions of Americans who are uninsured or underinsured in America today.

MR. DEAL. I thank the gentleman.

Mr. Bilirakis is recognized for an opening statement.

MR. BILIRAKIS. Thank you, Mr. Chairman.

How much does it cost? That is the question we ask almost daily. Why? Because we are smart consumers and want to know that we are getting the most bang for our hard earned bucks. This often does not apply, however, when talking about health care costs. Too many consumers have become oblivious as to how much our health care actually costs. We may know that we have to pay a co-pay to visit the doctor or go to the hospital but we do not know how much the tests they run or surgeons they provide actually cost, or who really pays for them. In many cases, it is not because we do not want to know, it is because pricing information is difficult to find or not available at all. I hope that is beginning to change.

We will hear from our former colleague and House Speaker Newt Gingrich in a few moments about how health savings accounts in his words have unleashed the value driven American consumer on the efficient health care market. I agree with Speaker Gingrich when he recently wrote that every American has their right to know price and quality information before making their health care purchases. I am pleased that Florida, led by Governor Jeb Bush, has been a national leader when it comes to increasing transparency in health care pricing. My State has established a website at Floridacomparecare.com which allows Floridians to research prices for various medical procedures at State hospitals and compare hospital to hospital patient outcomes in the State. Florida's Attorney General Charlie Crist, and the State's Agency for Health Care Administration, created a website at Myfloridarx.com to help consumers shop for the lowest prices in the area for prescription drugs. This prescription drug website provides pricing information on the 50 most commonly used prescription drugs in Florida.

Mr. Chairman, I am eager to hear today's witness and believe giving consumers better information about their health care costs can improve health care quality and lower prices. I look forward to working with you, Mr. Chairman, and members of the committee as we determine how to better educate consumers about their health care choices and the increased transparency in health care costs.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman.

Mr. Pallone is recognized.

MR. PALLONE. Thank you, Mr. Chairman.

According to my Republican colleagues if consumers have a greater financial stake in their health care and have access to better pricing information, they will be magically transformed into a Nation of health care bargain hunters that will help bring runaway health care costs under control. And I have to tell you, Mr. Chairman, I just do not buy it. I do

not think it works that way. I made up a little chart over here on the left which I am going to use during questions which basically tries to point out that, you know, if you think about what the Republicans said, they said, okay, I am going to open up the Sunday paper, I am going to look at an ad like that, you know, buy two stents get free same day installation best buy and somehow, you know, it is as simple as saying two stents for the price of one in order to figure out how you are going to save costs. And I just do not buy it. Again, I am going to talk about that later during questions.

But first of all, our Nation is nowhere near providing patients with the pricing and quality information they need or in the context that they can easily understand. I recently heard someone liken shopping for health care to putting together a thousand piece jigsaw puzzle and it is just that complicated. And providing public access to a hospital's charge master or price list I do not think changes that.

The second thing is who is going to want to buy a bargain basement pacemaker or get a mammogram done cheaply? When it comes to their health, people do not want, they want the best possible care available, not the cheapest care. A man who just had a heart attack is not going to shop around before he goes to the emergency room. Similarly, a woman who has a lump in her breast is not going to wait so she can search for the least costly biopsy. These people want to be treated for their illnesses as soon as possible. Even if consumers had access to pricing information and they were able to understand it and use it to shop around for low cost health care, consumer directed health plans would still do nothing to reign in out of control health care costs. That is because they do not address what is really driving health care spending; providing care for the elderly and people with chronic conditions. What my Republican colleagues suggest we force these people to clip coupons and shop around for their care. Just ask all the seniors that had to shop for a Medicare prescription drug plan how they would feel about doing that every time they needed to see a doctor. It would be chaos.

Now let us be honest about what is going on here. The truth of the matter is that consumer driven health plans are not about empowering consumers to take control over the health care nor is it about lowering prices. It is about shifting more health care costs onto the backs of those who were the most sick and the least able to afford it. And I do not think we should be fooled. The Republicans in this hearing today and their rhetoric, I think are trying to sell the American people a lemon. And this idea of this brave new world of consumer directed health care envisioned by my colleagues, I just do not think exists. It is not going to really result in any price reductions.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman.

We are pleased to have the Chairman of the full committee, Mr. Barton and I recognize him at this time for an opening statement.

CHAIRMAN BARTON. Thank you, Mr. Chairman.

I appreciate our panelists being here this morning. I am looking forward to hearing your testimony regarding the transparency in our health care market.

Unfortunately, the term health care market is an oxymoron in this country. Instead of a marketplace, we have a system that prevents patients from seeing how much their health care services actually cost. The health care system hides prices and it blurs quality and it is most perverse. The system treats the poorest like they were the richest and charges them the very most.

I can tell you personally that the moments during which a patient is not interested in learning the price of a health care procedure. I had a heart attack on December the 15th. When I was on the gurney in the emergency room at George Washington Hospital, I was not real interested in what the cost was. I was interested in what the quality was. As it turned out, what they billed Blue Cross Blue Shield was over $75,000. I think it was worth every penny of it but I do not know personally how much they actually paid, but I think it was worth every penny of it. It is a true statement though that if I had asked while I was in the emergency room what it was going to cost for these lifesaving procedures, nobody could have told me that was actually providing the treatment. The emergency room staff could not have told me, the doctor who provided the surgery procedure could not have told me, and quite frankly the hospital administrator could not have told me. And that is why health care costs are different from virtually from every other economic activity in our life.

Most of us would never agree to let a mechanic repair our car or have a plumber fix a leaky faucet without first receiving at least an estimate of what those expected costs would be. At the same time as I have just pointed out, we routinely seek treatment for vital health care services with no information about the comparative costs or the quality. And the power of the system is such that we never even think to ask.

I cannot think of another sector of our economy where consumers have less to say about it or have less say. By limiting patient's access to comparative information, we restrict competition and cripple the ability of market forces to make health care more affordable. Not surprisingly, spending on health care has soared in this country, but does anybody here feel like the quality of the care has improved at the same rate as its cost? We deserve a better health care system which breaks through the conspiracy of silence regarding health care prices and quality. Too often

patients are charged amounts that really do not accurately reflect real cost and rarely reflect the rate that providers are paid by private health insurers. These list charges should be shown the light of day to highlight their impact on unsuspecting consumers.

Uninsured individuals are sometimes charged the full amount of these charges while insured individual can still be effected by them if they go out of network or if your insure base is negotiated rates off of the list price. The Oversight and Investigations Subcommittee of this committee has done great work on this issue, and I would like to thank Congressman Whitfield and Congressman Greenwood, the former Subcommittee Chairman, for helping to bring to light some of the problems that we are talking about today.

We know that transparency in pricing does drive down the cost everywhere else in our economy. We have seen how better access to prices has allowed customers to receive lower prices for airline tickets, cars, and now even homes in some of the markets around our country. Price transparency forces sellers to compete and allows purchasers to negotiate better deals and save them more money. With increased transparency, consumers could examine pricing information. For example, to see that an arthroscopic surgery procedure must cost $5,000 at one facility in Florida, while the same procedure in another facility in the same town is listed at $12,000. Rather than trying to regulate or restrict variations, consumers could simply be given the ability to see the differences and spend their health care dollars as they think they should. Maybe the $13,000 procedure is worth it. Maybe it features the world's best surgeon. Who knows, but maybe it does not. If the patient does not see the value in spending the extra money, he or she should have the choice on spending less.

Some providers and insurance are already working towards greater transparency. We are going to hear from some of them today about what they are doing to show their enrollees the cost that they will pay at each provider in their area. These negotiated rates that insurers could make transparent which would be most helpful to patients who want to know what they will pay out of their own pocket for a specific procedure.

I want to applaud Congressman Lipinski who is here to testify today and another Congressman who is not here, Congressman Pete Sessions of Texas for their work on legislation that would provide consumers with better information about the cost and quality of their health care services.

Mr. Chairman, thank you again and I look forward to the hearing.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF THE HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Good morning. I'd like to welcome the distinguished witnesses we have before the Committee today, especially former Speaker of the House Newt Gingrich and my two fellow Texans on the panel. I am looking forward to the hearing today regarding transparency in the health care market.

Unfortunately, the term "health care market" is an oxymoron in this country. Instead of a marketplace, we have a system that prevents patients from seeing how much their healthcare services actually costs. The health care system hides prices and blurs quality. At its most perverse, the system treats the poorest like they were the richest and charges them the very most.

Now, I can tell you that there are moments during which a patient is just not very interested in learning the price of a health care procedure. When you need it to survive, issues of cost do not come to mind. But it is also true that if you asked, nobody could tell you. That's how health care is different from virtually every other economic activity in our lives. Most of us would never agree to let a mechanic repair our car or have a plumber fix a leaky faucet without first receiving at least an estimate of what the expected costs would be. At the same time, we routinely are expected to blindly seek treatment for vital health care services, with no information about the comparative cost or quality of these services. And the power of the system is such that we never even think to ask, even when the circumstance does not involve an emergency.

I cannot think of another sector of our economy where consumers have less say. By limiting patients' access to comparative information about prices and quality, we restrict competition and cripple the ability of market forces to make health care more affordable. Not surprisingly, our national spending on health care has soared, but does anybody here feel like the quality of their care has improved at the same rate as its cost?

We deserve a better health care system, which breaks through the conspiracy of silence regarding health care prices and quality. Too often, patients are charged amounts that do not accurately measure real costs and rarely reflect the rates these providers are paid by private health insurers. These list charges should be shown the light of day, to highlight their impact on unsuspecting consumers. Uninsured individuals are sometimes charged the full amount of these charges, while insured individuals can still be affected by them if they go out of network or if their insurer bases their negotiated rates off of the list price.

Our Oversight and Investigations Subcommittee has done great work on this issue. I want to applaud Chairman Whitfield and former Congressman Jim Greenwood for helping bring to light the great problems caused by a lack of transparency in hospital pricing.

We already know that transparency in pricing drives down the cost everywhere else in our economic lives. We have seen how better access to prices has allowed customers to receive much lower prices for airline tickets, cars and now even homes in some markets. Price transparency forces sellers to compete and allows purchasers to negotiate better deals that save them more money.

With increased transparency, consumers could examine pricing information and, for example, see that an arthroscopic surgery procedure would cost $5,204 at one facility in Florida, while this same surgery in another facility in the same town is listed at $12,926. Rather than trying to regulate or restrict these variations, consumers could simply be given the ability to see these differences and spend their health care dollars accordingly. Maybe the $13,000 procedure features the world's best surgeon and mints on your pillow every evening, but maybe it doesn't. If the patient does not see value in spending the extra $7,000, he should have the choice of spending less. That's how competition works, and it seems to work everywhere but the hospital.

Some providers and insurers are already working towards greater transparency. I know we are going to hear from one health plan today about what they are doing to show their enrollees the costs they will pay at each provider in their area. In many cases, it is these negotiated rates that insurers could make transparent, which would be most helpful to patients who just want to know what they will pay out of their own pocket for a specific procedure or office visit. I also want to applaud Congressmen Dan Lipinski and my fellow Texan, Pete Sessions for their work on legislation that would provide consumers with better information about the cost and quality of their healthcare services.

I've said it many times, but free markets work, and it's something I think the health care sector needs badly. Nobody's interested in turning the hospital into the health care supermarket, but when you're charged $50 for a mucus recovery system that turns out to be a box of Kleenex, something's wrong.

Greater transparency is important, both to control the growth of costs and eliminate inefficiencies, but also to get patients to take an interest in the cost-effectiveness of their care. Thank you Chairman Deal for holding this important hearing today, and I look forward to hearing from our witnesses on this subject.

MR. DEAL. I thank the gentleman.

I know recognize the Ranking Member of the Subcommittee on Health, Mr. Brown, for an opening statement.

MR. BROWN. Thank you, Mr. Chairman.

Thanks to our witnesses for joining us today. I commend our guests and colleagues, Mr. Lipinski and Mr. Emanuel and other members of both sides of the isle for their efforts to increase the information available to patients. Patients should pay a fair price for health care and that accurate information on price quality and effectiveness can in fact be empowering. I agree that no one least of all the uninsured should pay inflated prices for hospital care or any other health care.

There is an article in Monday's Congressional Quarterly about a letter our colleague Bill Thomas, sent to Health and Human Services Inspector General chastising that office for failing to calculate "an excessive level of charges" for hospitals and medical equipment suppliers. The goal Mr. Thomas described is to establish a standard price for each hospital service and piece of medical equipment. And providers who charge more than that price will be excluded from participation in Medicare and other programs. He called that scheme a powerful economic incentive, I call it price controls. Mr. Thomas went on to say that absent such a benchmark pricing system of "a broad transparent pricing initiative that concludes hospitals will fail before it starts." I am not questioning his logic or his goal, I am questioning that it is right to set prices for hospitals and wrong to negotiate prices for prescription drugs. Somehow it is okay to send small medical suppliers into bankruptcy unless they reduce their prices, but it is un-American to question why U.S. drug prices are two to five times higher than prices in other rich countries.

The pharmacies in our country could safely import medicine from these countries which would stimulate price competition. The Federal government could negotiate for reasonable drug prices forcing drug makers to strike harder bargains with other countries instead of gouging U.S. consumers. We can pass Mr. Emanuel's legislation and shed some light on the nebulous link between the price that drug makers charge and the true cost of their products. But the Bush Administration and Republican leaders in Congress do not take kindly to initiatives that take aim at the brand name drug industry, nor do they have any interest in going after the insurance companies. According to Health Affairs, 20 percent of health care costs are associated with insurance, administrative, and daily functions. Maybe if we had transparency for insurers we could get those costs under control.

There is one thing you can say about the current crop of Republican leaders whether in Congress or in the White House. You can say that they are loyal to their friends, particularly the ones with deep pockets. They are all for posting hospital prices and encouraging consumers to comparison shop. They are all for keeping hospitals and other providers out of Medicare unless they agree to the government price, but they will not hold the drug makers accountable for treating U.S. consumers, U.S. businesses, and the U.S. Government like a piggy bank. Why the double standard? My guess has something to do with political ties and dollar signs.

The two health care sectors are largely responsible for the dramatic increase in health care costs; hospital services, prescription drugs. We should not treat one like a sinner and the other like a saint. One more thought on transparent, accurate information is good, but all the information in the world will not shrink a $5,000 deductible. Price competition is good but the best price in the world will not transform health savings accounts into a pro-consumer initiative. HSAs are tethered to high deductible insurance. High deductible coverage shifts major costs onto consumers. If you have to spend $2,000 up front, your insurer is probably pocketing your premium and paying out nothing. Evidence shows that for many people, having a high deductible policy is the same as having no insurance at all. People on these policies have similar problems accessing and delaying care as those without insurance.

I was visiting a plant near my district yesterday where people who work there 25 years are making $14 an hour and they have a $2,000 deductible health insurance plan. They all agree, we just never go to the doctor or hospital unless we are just deathly ill, of course. There is a link to these poorly conceived policies and increased consumer medical debt. Whether your deductible is in your pocket or in your HSA, it is still your

money, it is still replacing dollars that used to be paid by insurance. Transparency is good, so is real insurance.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman.

I recognize Mr. Shimkus at this time for an opening statement.

MR. SHIMKUS. Thank you, Mr. Chairman.

And just for the benefit of our panelists, I will not go into the big debate and rebut, but I would just say that transparency is important; competition, individual choices, whether it is a full line of insurance of associated health plans or health savings accounts. I mean the more choices the better in getting the consumer involved.

By the way, I am taking this time to welcome my Illinois colleagues. First as was mentioned earlier, Mr. Lipinski has a bill along with a similar bill by Pete Sessions, that would require the disclosure of hospital and ambulatory surgery care center pricing. And obviously, I am interested in hearing how he proposes that helps in this price disclosure debate and I am glad that he is here. I am assuming he will be joined by my other Illinois colleague, Mr. Emanuel, and I am sure he is going to thank us for the Deficit Reduction Act and the fact that we have included the price disclosure on A&P prices which he has requested and which is part of his bill, so I think he will come thanking the Republican Congress and the Deficit Reduction Act, and I look forward to hearing his testimony.

With that, Mr. Chairman, I yield back my time.

MR. DEAL. I thank the gentleman.

Ms. Capps is recognized for an opening statement.

MS. CAPPS. I thank you, Mr. Chairman and thank you for holding this hearing today, for each of our witnesses for being here especially our colleagues in Congress.

I can tell even before we get to your testimony that there is a difference in this room between those who believe that health care is simply a commodity that can be bought and sold, and those of us who believe it is an essential service with the goals of quality and access.

I wish we were here to discuss other ways to expand health coverage to the growing number of uninsured in our country. But when it comes to health care, transparency of cost, as big as it is, will not necessarily result in patients receiving the best quality of care. And ensuring that patients receive the best quality of care has to be our primary objective. Making costs more transparent so that Medicare, Medicaid, the VA, and insurance companies can negotiate more appropriate rates of reimbursement makes sense, however, encouraging individuals to participate in health savings accounts and determining their obtainment of health care based primarily on prices could be a disaster for patients'

health. We can recall the study conducted by Employee Benefit and Research Institute which found that individuals participating in HSAs who earned under $50,000 per year are more likely to avoid or delay necessary medical procedures. If low-income people are forced to bear greater cost sharing and they cannot afford it, we can expect to see people foregoing inexpensive primary care, ending up in the hospital with expensive care once the condition has worsened. This will perpetuate a vicious cycle whereby patients will be left picking up the tab for expensive emergency and acute care because they were encouraged to spend less in the first place.

Individuals are less likely to consider costs in emergency situations that require high priced care. When emergencies arise, a patient's only concern should be accessing care as quickly as possible. Every American deserves to know that he or she can get the health care services they may require. Promoting plans that may discourage preventive and primary care are leaving low-income and sicker patients to pay higher costs. It will not result in the best possible quality care for our country. It is unrealistic to conduct health care that way. It is also unrealistic to compare choosing your health care provider like you choose a car or television set. When lives are at stake, there is no time for price shopping. And if someone is incapacitated, they certainly do not have a choice in the matter. But instead of worrying about worst case scenarios, let us try to prevent them by reducing the number of uninsured with the goal being that everyone have access to primary and preventative care.

I yield back the balance of my time.

MR. DEAL. I thank the gentlelady.

I recognize Dr. Burgess for an opening statement.

MR. BURGESS. Thank you, Mr. Chairman. And I too want to thank you for convening this panel today. We are very fortunate today in that we have two Texans on the panel, Dr. Goodman who is the Patron Saint of Patient Power, the book that he wrote many years ago, and Mr. Gedwed from my backyard down in North Richland Hills, Texas, who I will speak a little bit more of later on.

I came to Congress having owned a medical savings account for five years before I arrived here. I am a believer in medical savings accounts. When patients would ask me, gee, doctor, you always complain about HMOs and insurance companies, what would you recommend, and I never hesitated, I said, I would get a medical savings account. I made it available for every physician and non-physician staff member in my office. At that time, we numbered about 45. Only about five of us took it, but those of us who took it over the years saw the dollars in that account grow and it made me a believer in the private ownership of Social Security accounts when we had that discussion up here last year.

The number one things that drives me on every piece of legislation that I look at and every piece of legislation that I have hoped for that deals with health care or whether or not I cosponsor a bill has to do with affordability. We were told back in medical school that there are three things people look for in health care; affordability, access, and quality. And you can only have two at a time. Taking that to heart, I am only going to focus on affordability during my congressional tenure however long that is because I believe that the American medical system does provide quality care and I trust it to continue to do so and I believe we will increase access by increasing affordability.

The uninsured are not uninsured by choice, they are uninsured because they cannot afford the $9,500 insurance premium that we require them to pay because of the all the mandates that we put on health insurance. We need to take a minute and think about the phenomena known as specialty hospitals. Specialty hospitals have a mechanism at their disposal for reducing the cost of care by increasing competition, increasing the quality of care through communities, but we do have to be careful about not running out the community hospital while the specialty hospitals increase.

We also have to recognize that there is a dark side to transparency in the health care market. Opacity exists not because people like opacity, but because it brings value to the system. And as long as we require the cross subsidization of our Medicare and Medicaid programs, how is the private sector going to make up that difference? There is going to be a need for opacity in the system so we need to look at that.

Our Chairman brought up the issue about the mechanic and you do not go to the mechanic and leave your car without knowing what it is going to cost. But I would also submit to you the Government would never go to the mechanic shop and say since it is up on the rack anyway, we will pay for the brake job but the muffler and changing the transmission fluid are bundled in and those are just included in the cost of the brake job. We see this every day in the Medicare system in this country.

We do want to be careful not to disrupt what is already there and working and again, Mr. Gedwed, from my neck of the woods has a very valuable product that is proprietary, but he has assembled that product from public data that is readily available. I understand he has data on my practice performance. I hope it is satisfactory. I look forward to learning that today. I look forward to hearing the rest of our panel members.

Thank you, Mr. Chairman, I will yield back.

MR. DEAL. I thank the gentleman.

We are pleased to have the Ranking Member of the full committee with us and I will recognize Mr. Dingell at this time for an opening statement.

MR. DINGELL. Mr. Chairman, I thank you for your courtesy and I thank you for holding this hearing on price transparency.

I want to welcome my two colleagues, Mr. Lipinski and Mr. Emanuel, thank you for being here.

I want to comment about this matter of disclosing prices. It is a good thing, particularly if it is extended to prices on pharmaceuticals and for health insurance companies. I have less hope of that happening than I do for other things. The hope is that the consumers will know how much their health care costs then they will then be able to shop around for the best deal and therefore reduce the overall cost of health care; a wonderful hope.

That is the market. How medical care is currently administered and delivered, there is no guarantee that it will bring down health care costs. It has never been so as it is now administered, and if that process continues as it is, it probably never will, unless extraordinary changes are made. This is a gross misconception. Health care does not work like a trip to the grocery store or to buy a sink. You do not always know what items you need or even what items are available. And more often than not, someone else such as your physician is by necessity selecting the items that go into your shopping cart and also addressing the question of prices.

Transparency is not enough. In addition to prices, consumers must know about quality. Today's health care systems are a long way from having the infrastructure to support reasonable assessments and reasonable comparisons of quality. We need to encourage collaboration to promote the development of quality measures and studies of the comparative effectiveness of different medicines and treatments. Then we need to figure out how best to communicate this often complex information to those who are frightened and off times uninformed people who are in a state of a little desperation.

Of course the question we should ask is why now are we seeking to turn people out on their own in the health care market? Is an individual really going to be able to negotiating anywhere near as good a discount as an entity negotiated on behalf of tens of thousands of individuals? If an individual can, why are my Republican colleagues so intent on harnessing the power of the group to get better discounts through association health plans?

Finally, a central tenet of this consumer driven philosophy is shifting more financial responsibility onto families, passing the buck for the hospital bed down the line through high deductible health care plans.

American families are already burdened by out of pocket medical expenses. Sometimes they are terrifying in size and scope. More than one in five people with chronic conditions live in families with problems paying their medical bills. And research shows that the medical bill problems are more common amongst those in insurance with higher deductibles. Asking people to pay more does not necessarily produce better outcomes. It can, and frequently does, produce vastly worse. In fact, it has been shown to have a negative effect on care, most significantly for those who are of low-income or chronically ill. The end result is people skipping or delaying care. And the one remarkable thing about this is it results in much more costly treatment later and much larger costs to all concerned.

To conclude, more price transparency in the American health care system is a good thing but we should not delude ourselves into thinking it is a panacea for our Nation's health care costs or for the problems of the uninsured. I would note, speaking on the subject of transparency, that I have been having many meetings with my constituents lately on these kinds of subjects. I have been asked not once about price transparency. Many have asked me about the continuing and serious problems of the selection and other matters of Medicare Part D drug benefits. People are confused. People are outraged. People feel that they cannot come to a sensible or workable conclusion and that there is no place that they can get that kind of information. So I hope my friends in the Majority will find time in the coming weeks to allow the Democrats to have the additional round of hearings on Part D that we are entitled to under the rules of the House which we have requested.

I thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman.

Ms. Bono is recognized for an opening statement.

MS. BONO. Thank you, Mr. Chairman.

I just would like to thank our panelists and waive my opening statement.

[The prepared statement of Hon. Mary Bono follows:]

PREPARED STATEMENT OF THE HON. MARY BONO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Chairman Deal and Ranking Member Brown, I would like to take this opportunity to thank you for allowing a hearing on this important issue. It is critical that we evaluate how to increase transparency in our healthcare market. Improved transparency will improve the costs and quality of healthcare services.

A recent Wall Street Journal article pointed out that it is difficult to enlist consumers in the effort to reduce healthcare costs if they don't know what those costs are. Simply put, informed consumers make the best decisions and informed consumers need information. The public has a right to know price and quality information when making

decisions and what decision could be more important than choosing life sustaining and life saving medical services?

The healthcare industry should be centered on the consumer. Consumers rely on pricing and quality information to make intelligent and cost-effective decisions.

There are an estimated 45 million uninsured Americans, seven million of which reside in my home state of California. The uninsured are frequently victims of outrageous price gouging and, even worse, are generally unaware of the extreme prices that they will be forced to pay in the coming weeks. This is not right and it is simply not fair. I believe that increased transparency has an important role to play in creating a more level playing field for those who seek medical services. I also believe that it is an important step in establishing and maintaining a healthcare system that is cost-effective, efficient and accessible.

I look forward to hearing from our witnesses today as to what their policy recommendations are and how we can continue to move towards such a system.

Thank you Mr. Chairman and I yield back the remainder of my time.

MR. DEAL. I thank the gentlelady.

Mr. Allen is recognized for an opening statement.

MR. ALLEN. Thank you, Mr. Chairman.

I appreciate the importance of this hearing of providing consumers with better information about their health care costs. I think based on the conversation we have had already it is pretty clear that the information about quality is probably more important to a great many people.

I do question the underlying assumption of this hearing which is that if patients can easily obtain the price of different health care services they will then shop around for the least expensive care. Chairman Barton made it quite clear that when he had his heart attack that was not foremost in his mind and it is not likely to be foremost in the minds of others who have a serious health condition.

It is important that we deal with this system in all of its complexity. We mentioned a couple of things. We know that the health care costs are driven largely by people who have two or more chronic conditions and the treatment of that, those conditions, can be very expensive. We know that the increase in health care costs is driven largely by developing technologies and we know that compared to other countries, our system is much more expensive because of the administrative costs that come with a complicated private insurance system that is much more complicated and much more expensive than other countries have. But within the system itself there are also complexities.

Uma Rinehart has laid out I believe a compelling argument that if you combine HSAs with high deductible health plans, that shifts costs within the system or it shifts the burden within the system, within the health care system. Particularly it shifts costs from wealthier people to poorer people and it shifts costs from healthier people to sicker people. And that is something that is, that is a direction that consumer driven health care will take us--HSAs we saw just recently articles saying that 2

million people so far have taken out HSAs in this country but only 1 million have put any money into them. And the bottom line is if you are relatively wealthy in this society, you can set up an HSA, you can put money into that kind of account, and as Dr. Burgess said and others I will admit it works for people. But it does not work for people who cannot afford health insurance today. And it does not reduce the overall cost of the system.

One closing comment, when I first ran for Congress, I went to the head of the main medical center and he said well think of the health care system as being 14 percent of our GDP, a giant pool of money and every player in the system is getting a certain amount of money out of that pool and now he said just you try to change it. And that is the complexity. That is the difficulty. We ought to be looking at those things that will reduce system costs, not simply shift the cost of health care within the system to those who can least afford it and to those who are the sickest.

I yield back the balance of my time.

MR. DEAL. I thank the gentleman.

Ms. Baldwin is recognized at this time for an opening statement.

MS. BALDWIN. Thank you, Mr. Chairman and I thank the witnesses.

Like my colleagues, I support increased price transparency. And I think that price transparency efforts we are discussing today should go hand in hand with increased reporting of quality measures. We certainly do not want to encourage people to simply seek out the cheapest health care if that means sacrificing quality to do so.

In my home State of Wisconsin there has been a number of exciting efforts on both the price and quality reporting front. The Wisconsin Hospital Association has been a leader in this effort. They have developed two systems; one that reports on quality and the other that reports on charges and this information is now available on line. The Wisconsin Collaborative for Healthcare Quality has initiated a similar system that goes one step further. It combines both quality and pricing data in the same reporting system so consumers can look on one chart to see where a given hospital would fall on both the quality and price spectrum.

In order to truly educate consumers, we need to ensure that they are able to access the full picture. Consumers need to know about where they can get the best health care at the most affordable price. And in many aspects, the health care prices must be a part of this, including prescription drug prices. So our efforts regarding increased transparency must focus on both of these pieces. But I do think it is important to keep in mind that increased health care transparency has limitations as many of my colleagues have pointed out. Knowing that a certain procedure costs $500 in one setting and $625 in another does little to help a family

that has no health insurance and no spare resources to pay the price. Comparison shopping only works if you have the financial comfort to afford the purchase and the time and ability to investigate the options.

Similarly, I am concerned that proposal is such as health savings accounts which rely heavily on increased price transparency would predominately benefit the healthy and the wealthy in our society. Having a health savings account is not going to help a family who cannot afford to put money into their account. Instead, HSAs will only serve to accelerate the erosion of our already crumbling health care system by causing more employers to switch from comprehensive health care coverage to high deductible HSAs, weakening the risk pooling system that we have and making comprehensive health care coverage even harder to obtain in our country.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentlelady.

Mr. Green is recognized for an opening statement.

MR. GREEN. Thank you, Mr. Chairman.

I would like to welcome my colleagues on both sides of the aisle. And I support like all we have heard the efforts to provide additional transparency in the health care system to allow consumers and medical professionals and policymakers the insight into the cost of health care. But it is clearly the Administration's push for pricing transparency as part of the larger effort to promote health savings accounts and I would hope we can support price transparency without supporting health savings accounts. Now that health savings accounts are not part of the problem, the solution to deal with the lack of health care coverage, but I do not think it covers anywhere near the number of people that they think it would be. Because similarly not only with the increased health care costs but also the burden for negotiating their health care with the provider.

And I know, like our Chairman and all of us, when we go to a physician or a hospital specifically on an emergency basis instead of being able to say by the way I am going to save $50 by going to this one instead of that other one. And I believe pricing information should be available, but this information alone will not help consumers make better decisions. Consumers also need information about the quality of the care, the delivered products. And I know there has been an effort and I see that at least on the hospital side. So maybe we need to see both consumer information on pricing and also the quality as it is rated, otherwise consumers are likely to use the cheapest health care which may or may not always be the best. It is also practical to expect consumers to shop around. As I said for example, a pregnant woman has months maybe to make a decision about who is going to provide her

maternity care and can take into account the many factors but a parent with a child that needs an emergency surgery may not be able to. Getting the child the health care quickly is the most important factor in the parent's decision process.

The pricing transparency as part of the consumer directed health care is supposed to lower health care costs. We must also ask ourselves lowered at what price? If a 50-year-old with an HSA and a high deductible health plan knows the cost of a colostomy yet forgoes the procedure because of those cost implications, is that consumer really getting better health care? No, in fact, I think that is what we have seen from HSAs. People will postpone some of the easier things until they actually have to go and have the catastrophic and get to that $5,000 amount.

So that, Mr. Chairman, again, I think we can support price transparency and better consumer information without necessarily signing on to HSAs panacea for our health care crisis.

Thank you.

MR. DEAL. I thank the gentleman.

Mr. Pitts is recognized for an opening statement. I thank the gentleman.

Well we will proceed. I believe we have covered everyone's opening statements here. We will proceed with our very distinguished members of our panel. We are pleased to have two of our colleagues who are here to testify and I will recognize these two gentlemen first, and then we will proceed after that to recognize the other remaining members of the panel. First of all, we are pleased to have Mr. Daniel Lipinski who is here, a Member of our current congressional delegation from Illinois and his colleague also, Mr. Rahm Emanuel from Illinois is here as well. We will begin with you two gentlemen and Mr. Lipinski I will recognize you first for five minutes.

STATEMENTS OF HON. DANIEL LIPINSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; AND HON. RAHM EMANUEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

MR. LIPINSKI. Mr. Chairman, I would like to thank you and Ranking Member Brown who looks a lot like Mr. Pallone right now, and all the members of the Health Subcommittee for giving me the opportunity to speak about H.R. 3139, the Hospital Price Reporting and Disclosure Act, which I introduced last year with Representative Bob Inglis of South Carolina.

As health care costs continue to rise, families are struggling more and more to figure out how to pay for the medical bills. This problem is made worse by the fact that there is no way to know how much you are going to be charged when you check into the hospital for care. Lack of information prevents families from making well-informed cost-effective choices. That is why I introduced this bipartisan bill to require every hospital to give Americans clear, concise information about what they charge for common procedures and medications.

Many of us would never consider getting our car repaired without first getting an estimate. Well this is exactly what we do when we go into a hospital for health care. Two years ago, I was involved in a serious bike accident, a bicycle not a motorbike that has been sometimes reported. But in the sense that I broke my hip which was certainly the biggest shock but as anyone who has gone into a hospital has had happen to them, I got a second shock when I got the bill. Just to give you one small example, I was charged $5 for this tiny packet of ointment. When you go to any pharmacy and get the same thing 32 times the size for $7. Now this and the other costs charged to me on the itemized bill lead me to the question why can't we know what hospitals charge before we get admitted to the hospital. At that point, I do what most people do. I do a Google search to see if anyone else was working on this problem. I found that California had just recently required hospitals to disclose all the prices that they charge. That is the hospital's charge master. Now this disclosure revealed a big disparity between hospitals and what they charge for the same procedures. And actually one hospital cost $120 for the same chest X-ray another hospital costs $1,500. At one hospital they would give you a Tylenol capsule for free another hospital would charge you $7 for the same capsule.

So last year, I introduced the Hospital Price Recording and Disclosure Act, to make information available for all hospitals across the country and give all Americans the ability to make informed choices about where they seek medical care. This bill would require hospitals to report twice a year to the Secretary of Health and Human Services the average and median price that they charged over the last six months for the 25 most commonly performed in-patient procedures, 25 most common out-patient procedures, and the 50 most used medications. These prices would then be posted on a user friendly website where Americans could easily access them. This type of information would be simpler for the average person to understand than if the entire dense charge master list was provided.

Numerous States besides California have also taken recent action on this issue. My home State of Illinois has passed legislation to require disclosure of prices for both in-patient and out-patient procedures.

Florida, Georgia, Ohio, and South Dakota have all passed similar legislation. Wisconsin, as Representative Baldwin's talked about, has this type of information available on a public easy access website and I highly recommend that website. At least two more States right now are currently talking about this as they have legislation pending on hospital price disclosure. On a national level, it was initially reported that the Administration has discussed the proposal to have HHS implement and oversee a voluntary program that publicizes the prices health care providers charge for their services. All of these are a good start. I believe Congress should act to make price disclosure mandatory on a national level.

Obviously price is not the only factor that a family should take into account when making health care choices. Quality information is also critical and I am happy that the Centers for Medicare and Medicaid Services are making some of this quality information available now, but much more is needed. We must always remember though that when seeking medical care the advice of professionals will always be essential in making health care choices. But these are not reasons to oppose making hospital price information available. Price information is especially critical to 46 million uninsured Americans. A recent report on 60 Minutes demonstrated the high impact that undisclosed hospital prices have on uninsured Americans. While you work to get coverage for the uninsured which is something that is very critical, we should give them the information that will help them to make more cost-effective health care choices.

This issue is not Democratic or Republican. We not only have bipartisan support for this bill in the House, but a companion bill was introduced in the Senate by Democrat Dick Durbin and Republicans Jim DeMint and John Cornyn. President Bush has also stated his support for price transparency. When I am home in Illinois and I talk about this bill, they call it one thing, common sense. We expect to have price information for every other purchase that we make, why do we not have this information available when we go into the hospital? Because when it comes to health care, information is good for you.

I would like to thank the Chairman for this opportunity to testify and I look forward to working on this issue in the future with the committee. Thank you.

[The prepared statement of Hon. Daniel Lipinski follows:]

PREPARED STATEMENT OF THE HON. DANIEL LIPINSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman:

I would like to thank you, Ranking Member Brown, and all the members of the Health Subcommittee, for allowing me the opportunity to speak about healthcare price transparency, specifically, H.R. 3139, the Hospital Price Reporting and Disclosure Act, which I introduced with Representative Bob Inglis of South Carolina.

As healthcare costs continue to rise, families are struggling more and more to figure out how to pay their medical bills. This problem is made worse by the fact that there is no way to know how much you will be charged when you go to a particular hospital for care. Lack of information prevents families from making well-informed, cost-effective choices. This is why I have introduced the Hospital Price Reporting and Disclosure Act, a bipartisan effort to require every hospital to give consumers clear, concise information about what they charge for common procedures and medications.

Most of us would never consider getting our car repaired without first receiving an estimate of the charges, but this is exactly what we do when we need to go to a hospital for treatment. Two summers ago I was involved in a serious bicycle accident. Breaking my hip was certainly the most serious shock, but like anyone else who has experienced time in a hospital, I was hit with a second shock when I received the bill. Just to give you one example, a tiny single-use packet of ointment was billed to me at almost five dollars. If you walk down the street to any pharmacy you can get a tube 32 times the size for about seven dollars. This led me to ask the question, "Why can't we know what hospitals charge before we are admitted?" At that point I did what most people would do, conduct a Google search to see if anyone else was asking this question. I found that the state of California had just recently required hospitals to disclose their entire price list – their "charge master." This disclosure revealed that there was a great disparity between California hospitals in what they charge for common procedures and medications. One hospital charged $120 for a chest x-ray while another charged more than $1500. And while a Tylenol capsule was free at one hospital another charged over 7 dollars for the same medicine.

So last year I introduced The Hospital Price Reporting and Disclosure Act to make price information available for all hospitals across the country, and give all Americans the ability to make informed choices about where they seek medical care. This bill would require hospitals to report twice a year to the Secretary of Health and Human Services (HHS) the price they charge for the twenty-five most commonly performed inpatient procedures, the twenty-five most common outpatient procedures, and the fifty most frequently administered medications. These prices would then be posted on a user-friendly web site so that Americans could easily access this information. Our bill does not require the disclosure of the entire charge master because the experience of Californians has suggested that the size and complexity of these lists make it difficult for the average person to find helpful information.

Numerous states besides California have also taken recent action on this issue. My home state of Illinois has passed legislation that provides for disclosure of prices charged by hospitals for both in-patient and out-patient procedures, and states like Wisconsin and Oregon already have this kind of information available to the public on easy to access websites. I highly recommend the Wisconsin website (http://wipricepoint.org) to see how well this can be done.

Obviously price is not the only factor that families should take into account when making health care choices. Quality information is also critical, and I am happy that the Centers for Medicare and Medicaid Services (CMS) is beginning to make some quality measures available; more is certainly needed. And the advice of health care professionals

will *always* be essential when making care decisions. But these are not reasons to oppose making price information available.

Price information is especially critical to the 46 million uninsured Americans. The recent report on *60 Minutes* demonstrated the high impact that undisclosed hospital prices have on uninsured Americans. While we work to get coverage for the uninsured, we should give them information that will help in their health care choices. We expect to have price information for every other purchase that we make, why shouldn't we have the same when it comes to health care?

This is not a Democratic or a Republican bill. We not only have bipartisan support in the House, but Senators Dick Durbin, Jim Demint, and John Cornyn introduced a companion bill in the Senate. President Bush has also stated his support for price transparency and it's been reported that the Administration has discussed a proposal to have the Department of Health and Human Services implement and oversee a voluntary program that would publicize the prices healthcare providers charge for their services. But when I'm home in Illinois talking to my constituents, they call this bill one thing – common sense. Because when it comes to health care, information is good for you.

I would like to thank the Chairman for the opportunity to speak on my legislation, and I look forward to hearing the testimony of the other witnesses.

MR. DEAL. I thank the gentleman.

Mr. Emanuel, you are recognized for five minutes for your presentation.

MR. EMANUEL. Thank you, Mr. Chairman. Thank you for this hearing.

In the concept of transparency, I not only advocate for legislation as I have done on the prescription drug pricing and Medicaid Fraud Prevention Act--I also practice it. If you go to my website, you can see a Costco in Chicago pricing for ten of the most common drugs used by seniors and Costco in Toronto. Now the Costco in Toronto, and we update it every month, on average is $1,200 cheaper for those same ten drugs, same dosage, than they are at the Costco in Chicago. And I want everybody in the Chicago area to know and that is why I instituted it. And remember it is Costco which is a price competitive shopping area. It is the same ten drugs so we are comparing the same drugs that seniors most commonly use--blood thinners, arthritis, blood pressure, all types of medication. And so I believe in the notion of transparency is making people better shoppers and getting price competition.

That is also why I wrote a letter to the Secretary of Health and Human Services asking them originally when they put up on their website the pricing Medicare.gov that they include the prices in Europe which they--I know it is going to come as a shock to you, they did not do but for everybody to know then about the competition and what pricing was. That is why I believe in re-importation as a concept of allowing people access and allowing competition and choice to exist in the market and you can have price competition. And I practice that at our office so

people in Chicago, the old Costco in Chicago and Costco in Toronto. Toronto is an hour away and $1,200 cheaper for Chicago.

Now I introduced this legislation, which my colleague from Illinois, Congressman Shimkus said some of the stuff was implemented in the budget reconciliation but not all of it. Today, Medicaid covers about a third of the budget, a third of the cost of the budgets for our State governments. And we all know they are going on a fast track to about half the State budgets. And one of the biggest price points in there, if not the biggest, one of the driving factors is the cost of prescription drugs. And that is what we are paying now. I think about a third of the States right now pay more for Medicaid than they do for access to higher education. And in short order that is what we need for every State. That is going to happen. And prescription drugs and the price of prescription drugs is one of the driving factors there.

So we introduced this to give both competition and also as a way to fight fraud. Now what we did last year was halfway but not the full effort. And what we have to do is get all of the information, all of the transparency there, not just the average manufacturing price or the second, how you compute the average manufacturing price. Without that information, all that information we will never know. And in fact, in 2004, Schering-Plough settled with the Government for $345 million on the issue of pricing and Medicaid. There were also in 2003 Bayer, I think the exact price was $257 million and GlaxoSmithKline for $86 million. So in fact, fraud to taxpayers exists as it relates to pricing prescription drugs through Medicaid and the payments.

Lastly, we have to get the best prices out there. So although we have done certain things, we have to finish the job as it relates to transparency, otherwise taxpayers are going to continue to be paying for bills they should not be paying and paying money they should not be paying and we cannot have a position where Medicaid is going to go from a third of our State budgets up to half of our State budgets. And all this information would make our State governments and therefore our taxpayers better buyers of prescription drugs. We now know there is a problem up there. That is why we settled these cases in the last two years and made millions of dollars. But how you compute the average manufacturing price and the best prices is essential because right now we are playing hide the ball with the prescription drug companies and that is wrong. Now we know there is a problem here and we cannot do halfhearted efforts to get all the pricing and all the information. We would not have addressed it in the budget reconciliation unless we thought it was a problem and yet fraud is being committed on taxpayers, and on Medicaid, and on the consumers and yet we are not doing what we should be doing. And all we are asking for is the type of information

to be available. And as Secretary Michael Leavitt said just yesterday, people deserve to know, they have a right to know the quality of care they are receiving and its cost. And unless you know how you compute the average manufacturing price and unless you know what the best prices are available, we are never going to get the best costs for our taxpayers and for the people who use Medicaid, the most vulnerable in our society. And these costs are rising.

And I know I am out of time so I want to thank you very much for holding this hearing and hope that rather than doing half of it as we did last year, we finish the job this year when it comes to full transparency.

MR. DEAL. I want to thank both gentlemen for being with us and would invite you to join us on the dais if you would choose to do so.

MR. EMANUEL. I am on my way to a Medicare event on the issue of pricing.

MR. DEAL. Thank you for being here.

And Mr. Lipinski you have the same invitation to join us if you would like or I understand you have other schedules like most of us do. But thank you both for being here.

MR. LIPINSKI. Thank you.

MR. DEAL. It is my pleasure now to introduce the remaining members of the panel and they are certainly distinguished individuals. First of all my former colleague from Georgia and our Former Speaker of the House of Representatives, the Honorable Newt Gingrich, we are pleased to have you with us today. Mr. William Gedwed who is the Chairman and President and CEO of UICI from New Richland Hills, Texas that I believe Mr. Burgess referred to earlier in his statement; Mr. Paul Ginsburg who is President of the Center for Studying Health System Change, pleased to have you as well. Dr. David MacDonald, President of Liberty Health Group from Charlottesville, Virginia; Dr. Sara Collins, Senior Program Officer, Future of Health Insurance of the Commonwealth Fund from New York; Dr. John Goodman, President and CEO of the National Center for Policy Analysis from Dallas, Texas; and Dr. Gerard Anderson, Johns Hopkins Bloomberg School of Public Health and Health Policy and Management from Baltimore. Certainly a distinguished group and Speaker Gingrich we will start with you.

STATEMENTS OF THE HON. NEWT GINGRICH, FORMER SPEAKER OF THE HOUSE, FOUNDER, CENTER FOR HEALTH TRANSFORMATION; WILLIAM GEDWED, CHAIRMAN, PRESIDENT & CEO, UICI; PAUL B. GINSBURG, PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE; DR. DAVID MACDONALD, PRESIDENT, LIBERTY HEALTH GROUP; DR. SARA R.

COLLINS, SENIOR PROGRAM OFFICER, FUTURE HEALTH INSURANCE, THE COMMONWEALTH FUND; DR. JOHN GOODMAN, PRESIDENT & CEO, NATIONAL CENTER FOR POLICY ANALYSIS; AND DR. GERARD F. ANDERSON, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, HEALTH POLICY AND MANAGEMENT

MR. GINGRICH. Thank you, Mr. Chairman.

I very much appreciate this hearing and the focus on the public's right to know, to use Secretary Leavitt's language, I might point out to the committee that 93 percent of the country at least in one recent poll, said people should have the right to know price and quality information before they make decisions on health care.

I would also point out that in terms of fraud, there is dramatically less fraud in a place like McDonald's or UPS or FedEx than there is in Medicaid because you have a direct relationship between the buyer and the seller. If UPS or FedEx does not pick up your package, you do not pay them. And if they do not deliver the package, you call because you know what is going on. The New York Times reported that in Medicaid in New York State there is an estimated $4.4 billion a year in fraud, just in New York alone. And I think that is because the current system is inherently impossible. You cannot have a third party payment model in which for example in New York they had one dentist who applied for 982 procedures per day and got paid. The system is just simply hopeless.

And so I want to start with, and Congressman Allen made a point about, the complexity of the system and that is exactly why the Austrian School of Economics emphasizes markets. Because the Austrian School looked at the fact that if you hold all the decisions, and actually the original story was they looked at the pricing of fish in a pre-refrigerated world in Vienna and the fact that the price dropped every 15 minutes all day and that different people would come to buy fish at different times of the day as a function of how wealthy they were or what they were going to use the fish for. And their conclusion was that just in trying to price fish, the bureaucracy was hopeless because it could never keep up with the changing pattern of values and opportunities. Now you apply this to 15 or 18 percent of the economy and it is hopeless.

I mean, I said this years ago and got in trouble but I am going to repeat it. The Centers for Medicaid and Medicare Services is inherently a Soviet style command bureaucracy. It has 44,000 thousand pages of regulations. It is impossible. And if the Congress had simply found the fraud in New York State, you would solve all of your five year budget number without affecting anybody who was delivering honest health care. But you cannot find it inside the current model. George Rowe

wrote the perfect article in describing Gorbachev's crisis. And this says something that Von Misis and Hayek wrote about 70 and 100 years ago. He said Gorbachev was a true communist and he wanted to have Perestroika and Glasnost to have an open, innovative communist. And he said you are either for markets or you are for bureaucracy. But to try to be for half and half is like asking the citizens of your country for half of them to drive on the right side of the road and half of them to drive on the left side. It is not possible.

And that is the muddle we are in right now. We pretend we want a market oriented system. We have a Medicare system, a Medicaid system, a veteran system, a tri-care system that are in fact command bureaucracies. We have private corporations that go out and buy huge quantities of health insurance by a human resources department that is a bureaucracy. And then we wonder why you get all these problems. Let me give you a few examples. The current system is a hopeless mess. I would argue if you go to a market oriented system with real information, you will both get better care and lower costs, in fact, enough lower cost that I believe you could get to 100 percent insurance coverage with a savings. That is how big I think the waste and fraud is in the current system. And it is not the government one is better. The Florida Medicaid system, only 16 percent of the children get dental screenings, only 4 percent of the women get mammograms. Government delivered health care has not proven in this country to be a better system. Look at the Indian Health Service as an example.

I think that Congresswoman Baldwin was right; you ought to be looking at both quality and price. I think that is exactly right. We will not have a 300 million payer system with the savings out of the--by getting a better system. But let me give you a couple quick examples. Those who oppose the right to choose by citizens refer to emergencies and a $50 savings. Both are erroneous. Less than 1 percent of all the decisions in health care are a function of emergencies. More than 99 percent are decisions about which you can make rational decisions.

Second, the savings are radically greater than $50. The Henry Ford Health System in Detroit went through a model of putting the information about drugs on a PDA so that doctors knew price as well as drug choice. The first year on a million dollar investment they saved $3.5 million because doctors moved to less expensive drugs. You cannot put the congressional budget off. It is a score there which is another issue. You should have an accurate scoring caucus because nobody at this CBO can score marketplace behavior. In fact, they do not believe in it, they are a bureaucracy. And so the Henry Ford System invested $1 million and the first year saved $3.5 million and saved three hours per nurse per week of time not spent talking to pharmacists.

The second example, I would urge this committee to go to myfloridarx.gov which Governor Jeb Bush developed with great leadership from Alan Levine, the Commissioner of Health. They put in real pricing for the State of Florida. You put in your zip code, you put in the drug you want to buy, in one instance which was in my testimony which I have submitted for the record, in one instance for the same drug in a 2 mile area you can pay as much as $202 and as little as $131. So in that one transaction, we pass the $50 number that was mentioned earlier by one of your colleagues.

We believe that a Travelocity model which Med Impact has developed for us, that if you would force Medicare to move to a Travelocity model of real time pricing for real time choice, we think you would take 40 percent out of the cost of drugs, and it would be cheaper than Canada because theoretically the bigger markets should be less expensive. It is an anomaly of the current structure that the American market is expensive.

Finally, I recommend you go to floridacomparecare.gov which is another thing that Governor Bush has put up where you can look at the number of times a hospital performs a procedure, the price of the procedure, and the quality. And it turns out, by the way, consistently the best hospitals are cheaper. This is not like buying a car or jewelry. In health care, better systems have fewer mistakes, fewer infections, greater accuracy, move patients back home faster, and as a result your choice is a hospital that does 300 procedures a year or two. Always pick the 300 procedures because they actually know what they are doing, whereas the guy doing two is thrilled that he has another chance to experiment. So these are real cases.

Lastly, I want to encourage this committee to look at something we have run across at the Center for Health Transformation that I am absolutely amazed at. There are some medical device companies that now require hospitals to sign contracts that they will not, they cannot tell the patient or the doctor what the device costs. Now this is turning the price of the medical device into a trade secret in a way which is insane. I use that word deliberately. How can you talk about a free market? How can you talk about any kind of transactions and say that the price is secret? And I would urge this committee first of all to hold hearings on this which we have been checking on and find to be absolutely correct and we can submit contract language to you that has $65 billion a year in sales. And I would suggest to you that you ultimately want to move towards legislation that says any medical device that is going to be sold to any aspect of the Federal government which normally includes Federal employee health benefit plans, Tri-care, Veterans' Administration, Indian Health Service, Medicaid, and Medicare, the price ought to be public.

These are commodities. They may be scientifically based commodities, they may be sophisticated commodities, but they are commodities. If you walked into a store and said I would like to buy a TV set and they said well, we can show you four options but by the way we are not allowed to tell you the price. You would think they were crazy. And for medical device companies to be so arrogant as to think that they can keep their price a secret by contract, I think is a violation of everything that we are trying to accomplish in transparency, and I would urge you to look into that particular area as a particularly egregious example of an unjustifiable secrecy in the health system.

And I appreciate the chance to testify.

[The prepared statement of Hon. Newt Gingrich follows:]

PREPARED STATEMENT OF THE HON. NEWT GINGRICH, FORMER SPEAKER OF THE HOUSE, FOUNDER, CENTER FOR HEALTH TRANSFORMATION

Chairman Deal, Ranking Member Brown, and members of the subcommittee:

I appreciate the opportunity to testify today about how giving health consumers access to price and quality information for medical services will help us build a 21st Century Intelligent Health System that saves lives and saves money for all Americans.

If healthcare in America is to transcend the challenges of the future, America must build this 21st Century Intelligent Health System. Building such a system will require fundamental changes of the health system we know today, but they are changes that are absolutely necessary.

To get there, ensuring that every American has the right-to-know price and quality information about health and healthcare products and services is absolutely critical.

Let me describe a 21st Century Intelligent Health System. In a 21st Century Intelligent Health System, every American will be covered by insurance, have access to the care that they need when they need it, own their health records, and will be empowered to make responsible decisions about their own health and healthcare because they will have the right-to-know the price and quality of health products and services before making purchasing decisions.

In a 21st Century Intelligent Health System, the focus will be on prevention and wellness. Innovation will be rapid, and the dissemination of health knowledge will be in real time and available to all Americans. Reimbursement for health care will be a function of quality outcomes, not a function of volume.

We are right at the edge of moving forward toward a 21st Century Intelligent Health System centered on the individual. This system I am describing is a wholesale departure from the bureaucratic, third party payer model that has dominated our healthcare financing for the last forty years. The new model promises better health outcomes at lower cost.

In order to be successful in this transition, healthcare consumers must have complete and total access to information about their healthcare providers and the products and services they provide. Yet lack of price and quality information about various healthcare services may cripple this much-needed transformation before it can ever get off the ground.

Americans are accustomed to leading their lives empowered with the responsibility and knowledge to determine what is best for them. Outside of healthcare, we live in the world of Expedia, Travelocity, CraigsList and Consumer Reports. Within minutes, any citizen can find price, cost, and performance data on an infinite number of products and

services. This transparent system puts the consumer squarely at the center of the market—and as a result, consumers have more choices of greater quality at lower cost.

Healthcare is the only area of America's economy where the consumer and the provider have no idea what the goods and services they trade cost. Think about that for a minute. Patients and doctors truly do not know the cost of even a standard office visit, not to mention myriad of complicated procedures delivered in an emergency room.

Sometimes there is a very determined effort to keep the prices of medical products and services hidden and/or deliberately vague.

Not surprisingly, this has the intended effect of keeping prices artificially high for consumers because there are no natural market forces to create downward cost pressures.1 If healthcare were a real market we would see more choices of higher quality coupled with falling prices.

There is no other sector of our economy with as little information about price and quality as in the $2 trillion healthcare industry. American consumers can find all types of cost and quality information about cars, computers, homes and vacation destinations. It is even common these days for potential buyers and owners to have lengthy online discussions about the pros and cons of, and alternatives to, every make and model.

But this type of rich consumer information is sorely lacking when it comes to something as important as choosing a physician or a hospital. More important than the lack of available information about prices is the stunning absence of quality data in the hands of patients. Few Americans could tell you which of the five hospitals nearest to them has the best outcomes for cancer care, or obstetrics, or orthopedic surgery. Significantly, they would have trouble even getting this information if their health or their life depended on it. This is wrong and it must change.

Individuals are at the mercy of an antiquated system that has not kept pace with the technological advancement, transparency, and modernization that nearly every other industry has embraced. The information age has left healthcare behind, and the consequences are tragic: medical errors continue to kill thousands; costs continue to rise faster than inflation; the number of uninsured continues to climb; and consumers still remain at the edges of the system. We can change this. But in order to do so, informed and proactive consumers must be at the center of the healthcare system.

The American people clearly want this to change. In one survey, 93 percent of Americans believe they have the right-to-know price and quality information about their healthcare providers.

It's hard to find any issue that garners the support of more Americans. By comparison, "only" 91 percent of Americans support keeping the words "under God" in the Pledge of Allegiance.

January 1, 2004, will be looked back upon as the "big bang" in healthcare policy. It was on this date that health savings accounts (HSAs) became available to all Americans who buy private health insurance. This was the most significant improvement in healthcare financing in two generations because it began to unleash the value-driven American consumer on the inefficient healthcare market.

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[1] Take for example the elaborate efforts undertaken to maintain secrecy about the costs of certain implantable medical devices. Implantable medical devices (the devices used in cardiac, orthopedic and spinal surgeries) are one of the single biggest drivers of increased hospital supply costs today. What's driving and maintaining these hight costs? One factor is that it appears that device vendors often seek to hide the true costs of their devices behind confidentiality provisions that they insert into their contracts with hospitals. In a case that I've recently been made aware of, one device vendor claims that its pricing is somehow a "trade secret", and that hospitals that buy its devices may not disclose their prices to the doctors who use them, the private payers who reimburse the hospitals for them, or the patients who receive them. The inevitable result is that no price shopping can take place and price competition, a fundamental market force, can't take root.

The most comprehensive, real world survey of HSAs was released last week by the trade group America's Health Insurance Plans. It showed that nearly 3.2 million Americans own HSAs as of January, 2006. The U.S. Treasury Department estimates that there will be 14 million Americans with HSAs by 2010, less than four years from now.

We should extend the opportunity to own HSAs to those on Medicaid and Medicare, and allow them to enjoy the advantages of having more control over their healthcare dollars and the opportunity to build wealth by staying healthy.

Owners of HSA-health insurance plans are starting to ask their doctors a long-overdue question: "How much does it cost?" That question, so commonplace everywhere else in the economy, has been almost unheard of, until now, in the doctor's office. As the number of these plans grows, it will create greater and greater pressure for accurate information about prices and more and better information about quality of health services. In a world of Google, Ebay, Edmunds.com, Travelocity, and Craigslist, where detailed information is available on nearly everyone and everything, it is indefensible that healthcare lags behind.

U.S. News and World Report, for example, is looked to as the best rater of colleges and universities. Today, some private sector companies are also beginning to provide much more health information to rate healthcare services. Websites like Subimo and HealthGrades offer subscription services where paying customers can gain access to information about quality. Insurers like Aetna and Humana are in the early stages of providing their enrollees with details about hospital outcome data. Not all hospital administrators are enthralled with these rating systems, but up until now they have failed to develop a nationally agreed upon set of standards whereby hospitals would rank themselves. They may never agree, but because this information is so valuable to consumers, we must ensure that it is not kept from them.

Government at the federal, state, and even county level can play a critical role in addressing the dearth of price and quality information available to consumers of healthcare.

Secretary Leavitt and CMS Administrator Mark McClellan deserve considerable credit for pursuing more transparency with hospitalcompare.hhs.gov, which allows patients, family members, and physicians to get quality measures on how often hospitals provide the recommended care to get the best results for most patients. Available on the site is the standard recommended care that an adult should get if being treated for a heart attack, pneumonia, and other complications.

The Administration is also moving ahead with additional transparency measures. Over the course of the next several weeks the Medicare website will begin to display the prices it pays hospital and physicians. Additionally, the Office of Personnel Management is exploring the possibility of requiring plans participating in the Federal Employee Health Benefit Program to make public the reimbursement rates they pay to providers.

The State of Florida now has two websites FloridaCompareCare.com and MyFloridarx.com that display hospital price and outcome data, and prescription drug prices respectively. These websites cost less than $200,000 per year to operate. They are cheap and highly effective. Every state in America should follow Florida's lead and make this critical information available to all citizens.

An article from this past Sunday's *South Florida Sun-Sentinel* reports about the real life impact of the new web site MyFloridaRx.gov. I recommend this story by health writer Bob LaMendola to anyone wanting to learn about the tremendous price discrepancies in price for the same medicine in the same neighborhood. At Morrison's RX pharmacy in the city of Plantation, for example, 30 Nexium pills sell for $202. Two miles away at the Costco in Davie, the exact same pills cost $131. Visitors to MyFloridaRx can get the "usual and customary" prices for the 50 most common prescribed drugs in the state.

In an additional example, a month's supply of albuterol for asthma inhalers can cost as little at $6.16 at Sam's Club in South Florida. The average cost around the region is $21. Green's pharmacy in Palm Beach sells the identical product for $43 and it retails for $88 in Broward County at ProScript in Davie. This is the kind of information that is critical to asthmatics, particularly if they are uninsured, own a HSA, or don't have a co-pay and therefore have to pay for prescription drugs out of their own pockets. Now, they have an objective online tool to help them compare prices and save money.

At the Center for Health Transformation2 we have developed a model of drug purchasing called Pilot Rx modeled on Travelocity. We believe that this model could take between 20 – 40 percent out of the cost of prescription drugs by offering real-time online prices to patients. Each individual's plan would reimburse for 100 percent of the cost of the lowest cost generic drug in a therapeutic class. From that point on up, the patient would be responsible for paying the difference. This visibility of prices, we believe, would crash costs significantly.

FloridaCompareCare.gov is the other Florida website that is proving itself of significant value to patients and potential patients. This very user-friendly site allows visitors to search for a wide range of price and outcome data for all hospitals and ambulatory surgery centers in the state. Visitors can retrieve the risk-adjusted number of hospitalizations, average length of stays, charges, and readmission, infection, complication, and mortality rates for every facility in the state. Certainly this is data you would want and deserve if you or a loved one needed an operation.

Florida officials are also shining the light on the underperformance of the traditional Medicaid fee-for-service system. It turns out that only half of the children in standard fee-for-service are getting well child check ups. Only 16 percent of children are getting preventive dental screenings. Only 4 percent of women are getting mammograms. The highest death rates from breast cancer are among African-American women.

50 percent of Florida Medicaid beneficiaries are either black or Hispanic. These populations are two to three times more likely to suffer from asthma, diabetes, heart disease, and infant mortality. These figures are troubling to be sure. But they need to be out in the open before we can begin discussing how to close these unacceptable gaps in health outcomes.

Florida's innovative new Medicaid waiver includes important innovations in information transparency. It will include participation from a range of health plans that will receive risk-adjusted premiums per enrollee. HMOs, Minority Physician Network, or a hospital-based Provider Service Network will have their performance monitored by the state. The state will be measuring plans in a range of areas including: percentage of kids getting well child check ups, percentage of kids getting dental screenings, and the percentage of kids getting the proper vaccinations. Consumer satisfaction will also be measured. Most importantly, these measurements will be made available for all to see.

It is the nature of a science and technology based entrepreneurial free market to provide more choices of higher quality at lower cost.

Americans deserve exactly this but are not getting it from our current health system. A major reason for this is the lack of reliable, useful information about price and quality of health and healthcare products and services. We can and must do better in order to create a 21st Century Intelligent Health System that will save lives and save money.

MR. DEAL. I thank you.

Mr. Gedwed, we will recognize you next.

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[2] The Center for Health Transformation is a collaboration of transformational leaders dedicated to the creation of a 21st Century Intelligent Health System in which knowledge saves lives and saves money for all Americans. For more information on the Center and our Right to Know Project, please contact project director Jim Frogue at 202.375.2001.

I will say to all of you, we have made your testimony that you have submitted in advance a part of the record so you can feel free just to take excerpts from it if you would choose to do so.

Mr. Gedwed?

MR. GEDWED. Thank you, Mr. Chairman and members.

On behalf of the 2,700 employees of UICI, it is a pleasure to offer--

MR. DEAL. Would you turn on the microphone so we can hear you?

MR. GEDWED. Thank you.

It is a pleasure to offer comments today on price transparency in the health care industry. UICI, a New York Stock Exchange company based in North Richland Hills, Texas, is a leader in providing affordable health care coverage to individuals, small businesses, and the self-employed. For more than 20 years, UICI has focused on delivering innovative products and services to help our customers in 44 States better manage their health care needs.

As you know, most insured Americans receive their health care coverage through an employer sponsored plan. That coverage is costly, averaging just under $11,000 per year. Out of that, the employee typically is responsible for paying about 25 percent. In short, most Americans receive coverage that is highly subsidized by the employer. It should be noted, however, that the number of Americans receiving coverage from these employer subsidized health programs is declining as costs continue to rise. And even to make it clearer that at UICI, our customers live in very different circumstances. We serve the guy who owns the independent muffler shop on the corner, the entrepreneur with a start-up firm, and the single mom waiting tables. But most of our 1.2 million customers, if UICI was not there with affordable health insurance coverage, chances are they would have no insurance at all.

But a concept of consumerism has recently entered into the health care debate. Our members have always had to be smart consumers. When you have to pay 100 percent of the cost of health care coverage, you have to be a smart consumer. Health care decisions are some of the most important and potentially costly choices Americans face. Often these health care decisions are made without the benefit of knowing ahead of time the true cost and/or quality of that service. In fact, based on recent research, customers are likely to spend more time researching the purchase of a car or a computer than evaluating a doctor or hospital. Our company has changed that for our customers.

Through our HealthMarket division, we have pioneered benefit and price transparency. HealthMarkets award-winning web-based tools which took more than four years and over $100 million to build and perfect. We provide our members with unparallelled power to manage their health care spending. We believe consumers should have at least as

much information about health care cost and quality as they do about cars or computers. When the cost of health care coverage represents nearly 10 percent of our customer's annual income, it is our responsibility to ensure they have all the information necessary to make informed decisions.

While many of our competitors are today just beginning to introduce limited forms of price transparency, we already have invented true transparency into every facet of our business. Our members have access to detailed information on approximately two-thirds of the Nation's medical providers located in all 50 States. That means more than 430,000 medical professionals, 4,000 hospitals and medical centers, and 26,000 other resources such as labs, MRI centers, medical equipment providers, and home health care providers. Our members benefit from price transparency on more than 20,000 procedures or services from the cost of a routine office visit to a consultation by a specialist. Most important to our customers, all this information is available in advance of an office visit or procedure.

Now how do we provide this information to our customers? Our company aggregates information from provider networks in a wide variety of services and then we share it with our members in an easy to use format. We use a green, yellow, red pricing structure to inform consumers on the cost of a provider relative to their benefits. In short, we match the level of their plan benefits that we offer them with expected costs so our customers can seek medical care and not incur any out-of-pocket expense if they so choose. We provide the wealth of information over a range of channels, like the Internet, mail, and telephone access. In addition, when customers need help, trained nurses are available to guide them through the health care decisions.

And I am pleased to tell you our tools can be applied to help State and Federal agencies better manage their Medicare and Medicaid costs. In fact, today UICI is engaged in conversations with several State agencies about using our tools.

Be at rest that I look forward to a day when all Americans will have access to health care HealthMarkets customers have today.

Thank you very much.

[The prepared statement of William Gedwed follows:]

PREPARED STATEMENT OF WILLIAM GEDWED, CHAIRMAN, PRESIDENT AND CEO, UICI

On behalf of the more than 2,700 employees of UICI, I am honored to submit these remarks regarding price transparency in the health care industry. In particular, I'm here to emphasize our strong support for further actions the 109th Congress may consider taking to empower consumers to make better informed choices about health care.

UICI is a leader in providing affordable health care coverage to individuals, small businesses and the self-employed. For most of our 1.2 million customers, if UICI was not there to deliver, chances are they would not have insurance at all.

The word consumerism has recently appeared on the Health Care horizon. but for our company, it has long been a way of life – reflecting the special needs of our customers. Unlike most Americans who receive health care from their employer and pay only a fraction of the true costs of that coverage, our customers pay 100 percent of theirs.

For this reason, UICI for more than 20 years has focused on developing innovative products and services to help our customers better manage their health care.

Health care decisions are some of the most important, costly choices people face.

And yet, Americans often make them without any real way to evaluate the cost and/or quality of medical service providers.

Often these health care decisions are made without the benefit of knowing – ahead of time – this valuable information.

In fact, consumers are far more likely to use the Internet to research a car or computer than a doctor or hospital, according to recent research, including a survey our company commissioned last year. It is our position that one reason consumers don't use the Internet to research health care is it's simply not available to most Americans.

We believe that's wrong. Consumers should have at least as much information about health care cost and quality as they do about cars or computers. When the cost of health care represents nearly 10 percent of our customers' annual income, it's our responsibility to ensure they have all the information necessary to make informed decisions.

It is for this reason our company acquired HealthMarket in 2004. We saw great potential in HealthMarket's technology and innovative products, which pioneered the category of consumer-guided insurance.

The crown jewel of HealthMarket is its award-winning web-based tools, which provide cost and benefit transparency. These innovative tools took more than four years and over $100 million to build and perfect. Armed with these resources, our members enjoy unparalleled power to manage their health care spending.

While many of our competitors are today just beginning to introduce limited forms of price transparency, we already have embedded true transparency into every facet of our business. As a result of our commitment to our customers:

- Our members have access to detailed information on approximately two-thirds of the nation's medical providers located in all 50 states -- that means more than **430,000** medical professionals, **4,000** hospitals and medical centers, and **26,000** other resources such as labs, MRI centers, medical equipment providers and home health care centers.
- Our members benefit from price transparency not for just 25 or 30 procedures like some of our competitors provide, but for virtually every procedure and supply code imaginable – more than **20,000** procedures or services in all, from the cost of a routine office visit to a specialist consultation to knee surgery.
- Our members have access to health plans that utilize price transparency in more than a dozen states, with another five states currently pending.
- Our members have access to data that is updated monthly, putting at their fingertips the most comprehensive, up-to-date price information available in the marketplace.

Our members use our site to look up participating physicians and hospitals anywhere in the country and compare cost information.

Many of our customers are surprised to learn that excellent, board-certified doctors may charge vastly different prices for the same medical procedure.

Here's how our website works.

The first screen provides a quick overview of providers' charges. A unique "thermometer scale" allows members to visually scan the list of providers and quickly

determine who charges a lot or a little compared with the rest of the market. A doctor "In the Green" is less expensive than a doctor colored red. A doctor who is "In the Green" will not likely require any out of pocket payments from the consumer, after the deductible and co-insurance.

The low-cost physicians are listed first, with the high-cost physicians last. A physician can move up in the ranking by bringing charges into line with the rest of the market. that means providers compete, and they have an incentive to keep costs in check.

If members wants more detail, they can click to the next screen. This provides costs for each specific service a doctor or hospital provides. As I mentioned, we have cost data on more than 20,000 services or procedures, organized by their CPT code. For those without computer access, this information is also available over the telephone.

Most importantly, cost information is available to enrollees in advance of an office visit or procedure so that they may take this information into account when making healthcare decisions.

But not knowing the cost of services is just one major problem wih managed-care health plans. Two others are:

1. Enrollees lack any sense of ownership over the money they spend.
2. Information on quality, outcomes, and training of physicians and hospital staff is often hard to find.

Now, a word of caution. Some insurance companies seem to use the Consumer Directed term as little more than a marketing buzzword meaning "low benefits / low cost."

A plan that truly puts the consumer in the driver's seat must do several things:

- The plan must offer price transparency, as discussed.
- Members need a reason to care about price – a sense of ownership over the money they spend.
- Members need access to quality and outcomes information.

When insurance companies set up the co-pay as the only responsibility an enrollee has, it's no wonder the enrollee doesn't care what the overall charges are.

At HealthMarket, our consumer plans give enrollees a sense of ownership through several innovative structural designs:

-- The MAC, or Maximum Allowable Charge, is the foundation of all HealthMarket Consumer Guided plans.

The MAC is the maximum fee the plan pays for a given service. It is set for each covered service, with a large portion of contracted providers within a given area at or below the MAC. It is set locally, based on provider contracts. If the member goes to a provider who charges more than the MAC, the member is responsible for paying the difference out of his or her own pocket.

Providers who charge below the MAC and are depicted as "In the Green" on the member's website.

Market forces point the way to those physicians who charge reasonable rates in relation to their experience, location, and qualifications.

-- The StartWell Account is available in many plan designs and presents an excellent example of how to create a sense of ownership over spending.

On day one of coverage, enrollees take ownership of a spending account for many routine, preventive, and diagnostic care services (options range from $500 to $1,250). If the member ends the year with a positive balance, he or she is entitled to roll over all or a portion of that balance on renewal of the policy, which is added to the next year's replenished beginning balance. If the fund is depleted, routine services remain covered, but are subject to deductibles and coinsurance.

The StartWell Account is applied to services such as check-ups, mammograms, allergy testing, and lab tests - all with no deductible, coinsurance, or co-payment. This

plan design is actually richer than most co-pay plans, but with the critical difference that the enrollee now has his or her first experience in caring about the cost of care.

Our members receive a rich benefit for preventative, diagnostic care – but also have a strong incentive to spend money only when needed - and to take cost into account when choosing a provider.

Many CDHP companies today use Health Savings Accounts (HSAs) to create a sense of ownership over healthcare spending. These accounts set up a personal financial asset that enrollees can spend as they see fit.

This is an excellent way to encourage consumerism since enrollees now have a personal stake in their spending. What is important - and often lacking - is that the insurance company must give enrollees the tools and information they need to be able to spend their own money wisely. This means knowing the costs before buying services. The best HSA plan, without cost information, is only half the puzzle. It's a superficial solution that leaves enrollees frustrated and unable to spend their own money wisely.

In addition to cost transparency, a consumer guided plan must provide access to provider quality and outcomes information.

We believe that to focus only on the money and not on quality would be to miss the whole point of health care.

We provide our members with access to best-in-class quality data from Subimo.

Our partnership with Subimo gives our members information on doctor backgrounds – such as board certification, medical school, and years in practice.

It offers information on hospitals such as adherence to patient safety standards, volume of procedures, and clinical outcomes.

Our website even allows enrollees to offer feedback on physicians, so that once results are made available, one enrollee will be able to benefit from the feedback of another, just as eBay or Amazon.com users can read what other users have said about various sellers.

All this information is made available to enrollees before they make what may be life-altering healthcare decisions. The goal is to provide the most information for the best decision possible.

Our members also receive access to detailed sources of health information such as in-depth health libraries. These enable enrollees to research symptoms, conditions, and treatments; determine a physician's hospital-admitting privileges; and even compare hospital survival rates for various procedures.

As much as a Consumer-guided plan tries to make life easier for members, health care consumerism can be complicated. Therefore, it is imperative to provide members with outstanding education and support. Without this component, plans may frustrate customers who understand the importance of making wise spending decisions and who know that the information is out there somewhere – but just don't know how to navigate the system to get it.

The otherwise glowing McKinsey & Company June 2005 report found an "Achilles' heel" in many consumer plans: 80 percent did not provide sufficient information on the prices doctors charge. Less than half of the consumers studied reported that they were at least as satisfied with their consumer-driven plan as they had been with their previous plan. "The long-term success of CDHPs will be highly dependent not only on whether consumers receive appropriately transparent information to help them make decisions, but also on whether the information can be easily obtained," the report concluded.

We offer an unparalleled array of support services that help to make them savvy users of the consumer tools described above. Following are just a few examples.

Our Consumer-Guided members are asked to participate in A "Verification Call" upon joining the plan. This call allows a customer service representative to describe in detail how the plan works and how the member can use the online and telephonic support tools to their advantage.

Another source of education about the plan are our *personal assistants.* In addition to handling traditional health insurance questions, these representatives are trained to discuss the critical issues faced by healthcare consumers: how to compare costs among various providers; how to use online self-service tools; and how to manage financial accounts, such as the *StartWell* Account.

The *Personal Assistant* program allows enrollees access to a toll-free number staffed by professionals who act as a *concierge* service. Some of the actions they take on behalf of enrollees and their family members include

- Getting medical records transferred
- Arranging for transportation
- Discussing bills or unexpected charges with the provider
- Finding home-care or adult daycare programs for an enrollee's elderly parent
- Setting up appointments to see specialists
- Putting the enrollee in touch with our 24/7 Nurse Line.

In Conclusion...

Consumer guided plans should be evaluated based on whether they provide:

-- price and quality transparency
-- a sense of ownership over health dollars spent
-- and adequate customer support.

The nation did not arrive at its current consumer-unfriendly system overnight, so unleashing the power of consumerism in America will take time. We at HealthMarket look forward to a day when most Americans become strong health care consumers. We look forward to a future that offers top-notch health care without skyrocketing costs that have come under the current system of managed care.

At HealthMarket, we believe in a future where all health plans sold in America will be of the consumer-guided variety - serving consumers who are able to manage their healthcare decisions as well as they do their vacation-planning or refrigerator inventory.

We are building this future now, because consumerism in health care is an idea whose time has come.

MR. DEAL. Thank you.

Dr. Ginsburg.

MR. GINSBURG. Thank you, Mr. Chairman, members of the subcommittee.

I am President of the Center for Studying Health System Change which is an independent, non-partisan, health policy research organization funded principally by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. Its mission is to provide policymakers with objective and timely research on developments in health care financing and delivery and their impacts on people.

With funding from the California HealthCare Foundation, HSC has conducted research on shopping for price in medical services. The research has covered the overall potential of the approach to improve value, and the experience in self-paying markets such as LASIK, and working papers on these two studies are available on request.

My statement makes three key points. First, fostering price shopping does have the potential to contain costs. Some people will use higher

value providers and many providers will feel market pressure to increase the value of their services. But some are overselling the potential of price shopping to solve our health care problems. For one thing, many services are too complex or too urgent for effective shopping and those patients responsible for the bulk of dollars spent in health care are beyond the reach of patient financial incentives in typical benefit structures.

The second point is that health plans play a key role in consumer price shopping but some advocates have been ignoring this role. Health plans have long been consumers most powerful asset through their substantial discounts negotiated with providers. As benefit structures change to put more emphasis on price shopping, a lot of innovation and tools to increase plan value are starting to go on like my colleague mentioned from his company. Some of these innovations are high performance networks providing incentives for patients to use providers with higher value data on the right of costs of different providers. Insurers basically have the potential to employ their formidable data and analysis resources to translate the complexity of health care pricing into something usable by consumers. Forcing disclosure of contracts between health plans and providers especially hospitals will have unintended effects of raising prices. It is well known in anti-trust circles that in concentrated markets, posting of price information leads to higher prices. It can do this either by facilitating collusion among sellers or buyers and also by leading to smaller market share gains for those who are willing to offer discounts. My testimony describes a well intention attempt at disclose that misfired.

Third, consumers experience in self-pay markets, such as LASIK, have been romanticized. We studied LASIK, dental crowns, in utero fertilization, and cosmetic surgery. We found serious price shopping only in the market for LASIK. There has been a decline in price for LASIK over time but consumer protection has been a problem and the FCC and State Attorney's General have been involved for a number of years. Some of the issues are misleading advertising. For example, the commercials for $299 per eye are very misleading because very few people are eligible for that price. In fact, only 3 percent of LASIK procedures cost less than $1,000. Second, misrepresentation of what services are included in the price is also a consumer protection issue. And one implication of the LASIK experience is the degree to which the presence of insurers actually prevents some of the consumer protection issues that we found.

In conclusion, increased price transparency is generally a good thing but it will not solve all the problems of the health care system, not even the problem of decreasing affordability of health care. And we must

proceed with caution and selectivity providing information truly useful to consumers and not inadvertently increasing the power of entities in concentrated markets.

Thank you very much.

[The prepared statement of Paul B. Ginsburg follows:]

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

Mr. Chairman, Representative Brown and members of the Subcommittee, thank you for the invitation to testify about providing consumers with better information about the cost of health care services. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded principally by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research.

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

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 make three points:

- Fostering consumer price shopping for health services does have potential for containing costs without sacrificing quality—but some are overselling the magnitude of this potential.
- For most consumers who are insured, their health plan has long been their most powerful asset in shopping for lower prices, and insurers have the potential to 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.
- Consumers' experiences with markets for self-pay services, such as LASIK, have been romanticized and do not offer much encouragement as a model of effective shopping for health care services without either a large role for insurers or regulation.

BACKGROUND

I perceive the current policy interest in price transparency as essentially a second stage of the evolution of consumer-driven health care. The first stage was financial incentives for consumers in the form of greater cost sharing—high deductibles and greater coinsurance. Now, we are focusing on the tools needed by consumers to make effective decisions on reducing the costs of their care. As insurers compete vigorously to sell consumer-driven products, they seek to differentiate their products on the basis of the

[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.

tools offered to consumers to compare price and quality across providers. Policy makers are interested in government's role in fostering greater cost-consciousness and a more favorable environment for consumers to make informed choices about health care services.

Traditionally, health insurance has either removed or sharply diluted consumer incentives to consider price in choosing a provider or treatment strategy. It is difficult for consumers to get price and quality information from providers, who have to date shown little interest in competing for patients on this basis. Likewise, there is little information available to help patients examine the effectiveness of treatment alternatives. The lack of quality information understandably makes consumers reluctant to choose a provider on the basis of a lower price. It is one thing to wind up with a low-quality provider when price is not an issue but another to get there as a result of opting for a lower price. Similarly, lack of information on effectiveness of treatment alternatives makes consumers more reluctant to consider price in the choice of treatment.

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 managed care plans 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.

POTENTIAL FOR MORE EFFECTIVE PRICE SHOPPING

If you define effective shopping as obtaining better value for money spent, then consumers do have the potential to be more effective shoppers for health care services. There are direct and indirect benefits of choosing providers that offer better value. The direct benefits are simply the cost savings, for example, of choosing the lower-cost of two providers of comparable quality.

But the indirect benefits are potentially more important. If enough consumers become active in comparing price and quality, this will lead to market pressure on providers to improve their performance on both cost and quality dimensions. Providers that measure up poorly on the value dimension will lose market share and will be motivated to revamp their operations to remain viable. Our market economy offers many examples of competitors responding to loss of market share by making difficult changes and regaining their edge, and examples are starting to appear in health care as well. The gains from providers improving their operations will accrue broadly to the health care system.

But 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 the maximum on out-of-pocket spending. Recall that in any year, 10 percent of people account for 70 percent of health spending, and most of them will not be subject to financial incentives to economize.

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. 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.

Even when services are good candidates for shopping by consumers, comparison of prices is not easy. Much treatment is customized. For example, an elective rhinoplasty, more commonly known as a nose reconstruction, is not a commodity, and a plastic surgeon cannot provide an estimate without examining the patient. Often a medical treatment involves an uncertain number of services by a number of separate providers, but few bundled prices are available in the marketplace today. As mentioned above, limitations in useful comparative quality data make patients reluctant to choose a provider based on lower price.

Shifting from choosing a provider to choosing treatment strategies, the absence of neutral financial incentives for providers is a serious problem. The most typical situation today is one where the provider gets paid on a fee-for-service basis, so the incentive is to recommend more services, especially those that have higher unit profitability.[2] Increasingly, physicians have an ownership interest in services, such as imaging, beyond their usual professional services, creating an additional conflict between physicians' interests and those of their patients.

SELF-PAY MARKETS

Many have pointed to markets for medical services that are not covered by insurance to show the potential of consumer price shopping. Since these services are not medically necessary—the basis for not being covered by insurance—they should be prime candidates for more effective consumer price shopping. HSC has studied markets for LASIK, in-vitro fertilization (IVF), dental crowns and cosmetic surgery by interviewing providers, consultants and regulators in these fields. Our findings are not as encouraging as one hears from advocates of consumerism.

LASIK has the greatest potential for effective price shopping because it is elective, non-urgent, and consumers can get somewhat useful price information over the telephone. Prices have indeed fallen over time. But consumer protection problems have tarnished this market, with both the Federal Trade Commission and some state attorneys general intervening to curb deceptive advertising and poorly communicated bundling practices. Many of us have seen LASIK advertisements for prices of $299 per eye, but in fact only a tiny proportion of consumers seeking the LASIK procedure meet the clinical qualifications for those prices. Indeed, only 3 percent of LASIK procedures cost less than $1,000 per eye, and the average price is about $2,000. I can only wonder about the extent to which policy advocates have themselves been deceived by these advertisements and inadvertently perceived a sharper decline in prices than has been the case.

For the other procedures that we studied, we found little evidence of consumer price shopping. For dental crowns and IVF services, many consumers are unwilling to shop

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[2] See Paul B. Ginsburg and Joy M. Grossman, "When the Price Isn't Right: How Inadvertent Incentives Drive Medical Care," *Health Affairs*, August 9, 2005.

because they perceive an urgent need for the procedure, and other consumers are discouraged from shopping by the time and expense of visiting multiple providers to get estimates. In cosmetic surgery, a limited amount of shopping does occur, facilitated by free screening exams offered by some surgeons. However, quality rather than price is the key concern to most consumers in this market; in the absence of reliable quality information, most consumers rely on word-of-mouth recommendation as a proxy for quality, instead of shopping on price.

ROLE OF INSURERS IN PRICE SHOPPING

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. Even though managed care plans have lost some clout in negotiating with providers in recent years, they still obtain sharply discounted prices from contracted providers. Indeed, in my experience as a consumer, I often find that the discounts obtained for the PPO network for routine physician, laboratory and imaging services are worth more to me than the payments by the insurer.

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.

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 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 likely to 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.[3]

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.

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[3] I do not have such concerns about physician prices because the physician services tend to be far less concentrated than hospital services in most markets. But information on contracts with physicians would not be particularly useful because prices paid by insurers vary much less.

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.[4] Drawing on this and other experience, the Federal Trade Commission in 2004 testified in the California Legislature against Assembly Bill 1960, which would have required the disclosure of certain price information from contracts between pharmacy benefits managers (PBMs) and pharmaceutical manufacturers.[5]

Some health plans are now experimenting with ways to communicate to their enrollees the fact that certain hospitals have particularly high or low negotiated fees, without violating their agreements to hospitals and their desire to maintain the confidentiality of their price negotiations. For example, Blue Cross of California, which tends to rely heavily on coinsurance in its benefit structures, has been posting ratings of the costliness of hospitals for PPO enrollees. It follows the approach of Zagat guides to restaurants, where "$" is assigned to the lowest cost hospitals and "$$$$" is assigned to the highest cost hospitals. This approach not only maintains the confidentiality of contracts with hospitals, but it also engages the formidable actuarial resources of the plan to simplify complex and voluminous hospital data for consumers. Humana Inc. has presented hospital price information to some of its Milwaukee enrollees that maintains confidentiality by using ranges and combining hospital costs with physician costs. I expect that insurers will come up with more innovative ways to present price information to enrollees.

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 from making consumers more effective shoppers for health care. Whatever the gains from increased shopping activity, rising health care costs will, nevertheless, price more consumers out of the market for health insurance and burden governments struggling to pay for health care from a revenue base that is not growing as fast as their financing commitment. For those who have health insurance, their health plan will be a key agent in facilitating their obtaining better value. Government needs to take care not to interfere with this relationship and should focus instead on the needs of those without insurance.

MR. DEAL. Thank you.

Dr. MacDonald?

DR. MACDONALD. Thank you very much, Mr. Chairman and Ranking Member Brown.

I am Dan MacDonald. I am a family physician. And I would like to share some thoughts from the front line. I have listened with interest to some opinions. They have been very interesting opinions of people that are not even involved in the situation.

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

[5] Federal Trade Commission, Competitive Effects of California Assembly Bill No. 1960, V040027, (September 7, 2004).

One is the situation of health care delivery, how does it impact the uninsured? I would like to share a few thoughts with you. As a family doctor, I started posting my prices in 1997 and I did that because I could not stay alive with the reimbursement from insurance carriers. I had people come in and see me that did not have insurance. For example, one guy came in and he needed to have his hernia repaired. He is a construction guy, had no insurance, and he came in. So what did I do? I called the local hospital. I found out that the bill was going to be $10,000 plus. Actually I did a price comparison on my own back in '97 which was very hard. I found out it was actually $15,000. So this guy did not have that. What can we do? I called a surgeon that I know, a very good surgeon, anesthesia, told him the situation. We got everything done for $1,800. The guy could easily pay $1,800. He could not even fathom paying $15,000. As a result, an old man on the work site came to see me. He said, I have a hernia, too. I put off getting care because I do not have insurance but I can afford $1,800. Can you set up the same deal? So we did it.

I am here to talk about practical application, not theory. I am not in politics. I appreciate the tennis games that happen in politics, but let me tell you from the streets it hurts. How does transparency hurt the uninsured or the lack of transparency? I included in my briefing a recent example in California. Somebody asked me to help them with their hospital bill. He was uninsured, hospitalized, did not plan on it, certainly did not plan on the bill that he got. And if you look at the briefing that I did, I summarized Tri-Care pricing. It is the only reference point I could get, the hospital would not give me any prices, they would not deal with me, it was very tough. I took the bill that they gave him and if you look at the comparison that this uninsured person was expected to pay just in two areas they expected to pay ten times what they are accepting from insurance carriers. This is the reality of what the lack of transparency is doing.

Am I a fan of HSAs? I love the application. The concept is a great, but the application is not so great for this reason. There is no real transparency when you are passing dollars in those health care HSAs. For those that are in favor of HSAs, I applaud you, it is a good deal. If you are not including transparency on what the thing costs, you are in la-la land if you think it is going to control costs over time. It just is not. We have to have transparency on the insurance end. We have to have transparency on the pharmacy end.

In my little world, and I remind you, I am going to remind you I am only a family doc, okay? But in my world a pharmacy, here is what happens. The drug is not that expensive when it hits the streets. What do I mean by the streets? When it comes out of the pharmacy, the

production line, it is approved, and then it goes through the pipeline. There are so many little people that are taking off money and rebates. There are so many funny things happening, we have to address that issue. One small company we helped in Spokane was able to save $55,000 just on the pharmacy rebates. How about lab cost? Well in my world costs, if you go through the insurance world, a typical panel of chemistry lipid, thyroid, and CBC will cost about $400 to $500. How do I know? I just had it done. Six months ago I had it done, and I thought that is crazy. There has got to be a better way. While through a lot of other venues were able to get that same group of tests for $89. So we are able to bring down costs for the surgery, we are able to bring down costs of pharmacy when you get all the middle people out. We are able to bring down costs of out-patient costs when there is real transparency.

I am here today to ask this committee for help. The hospital is a big deal. They are some very powerful folks and without your help transparency at the hospital level is almost impossible. I appreciate one side of this room saying that they are in favor of hospital pricing but let us not just focus on hospitals. I applaud you. Let us have transparency on everything. The uninsured are uninsured for a reason. I believe we might have 250 million over-insured and 42 million underinsured. I believe the market will drive costs where they need to be. I believe you can take out the waste, the administrative waste, and in Washington State it is reported to be 68 percent of every dollar that goes through the health care pipeline. Let us get the waste out. There is enough money in there.

Here's the kicker, let us not be naive to think providing insurance for everybody answers the problem. Why do I say that? There are two references in my briefing. One is from USA Today, Kaiser Family Foundation, and Harvard. They did a survey and they found that of those wrestling to pay health care costs, 61 percent had insurance. If you do not believe that, look at the Harvard study where 47 percent of bankruptcies were related to health care costs. And if you read the study, 75 percent of those had insurance. So let us not be naive to think that providing insurance is the panacea that is going to fix it.

I am a free market guy. I love free market because it works. I also want to take care of the uninsured. I get frustrated with health care when it becomes a ployable tennis match.

Thank you very much. I guess that means I am out of time, thank you.

[The prepared statement of Dr. David MacDonald follows:]

PREPARED STATEMENT OF DR. DAVID MACDONALD, PRESIDENT, LIBERTY HEALTH GROUP

Chairman Deal, Ranking Member Brown, and members of the Subcommittee…

I appreciate the opportunity to testify today about the need for transparency in health care prices. As a family physician, former residency director and LTC, U.S. Army, co-founder of SimpleCare, and President of Liberty Health Group, I have a wide variety of experience. Today the focus is transparency.

Most will never experience what the uninsured/underinsured face when trying to access health. You may be surprised that it could take more than a dozen phone calls before you get an answer to a simple question, "What does 'this' cost?" One can even outline scenarios of care (complicated/ uncomplicated visit; EKG; Echo; etc) and it is still a challenge to get a price. If the educated have a hard time getting a price, imagine how challenging it is for those who know nothing about the system!

I recently visited a prestigious university medical center for a cardiology visit. I received bills that were four times the amount quoted! Also, I observed courtroom proceedings by this hospital for "judgments" of unpaid hospital bills. Those in court were the ones who should benefit from the non-profit status afforded hospitals. We cannot expect hospitals to give away care, but neither should they continue with billing practices that border on extortion.

"I know what I know; I know what I don't know; but I don't know what I don't know." Robert Ricciardelli

Nobody would tolerate a "managed grocery" card that enabled you to go the grocery store, purchase various items and then get a bill 30 days later. Either the purchaser of the card would financially collapse because consumers abused the card; or the consumer would become irate when they had to pay their bill. Basically, this is what is happening in health care.

For those who think that providing insurance for everyone is the answer, there are two reports that suggest that this will not be the answer many hope for…

USA Today/Kaiser Family Foundation/Harvard Survey regarding health care – of those who reported experiencing challenges paying medical bills, 61% had insurance.

Health Affairs, 2 February 2005 – 47% of bankruptcies are related to medical bills; yet 75% had insurance at the beginning of the medical challenge.

Without addressing transparency issues, providing insurance is not the answer. Individuals must still pay their maximum out of pocket charge and other bills not covered by their insurance (Ambulance services). Many believe increasing costs of insurance is because the cost of health care is rising so fast. When health care costs are insulated from free market forces, costs escalate at a rate much greater than medical inflation.

According the *Health*INFLATION News (3/31/04; Vol. 13, No. 3), inflation for various aspects of health care is as follows:

Annual Inflation Health Care Indexes	**March 2003**	**February 2004**	**Net Increase in inflation**
Dental Care	3.6	5.2	1.6
Eye Care	-0.1	1.4	1.5
Medical Equipment	-0.2	1.2	1.4
Non-prescription drugs	1.2	1.6	0.4
Physician Care	3.0	3.4	0.4
Health Care	4.3	4.2	-0.1
Prescription Drugs	3.7	2.8	-0.9
Inpatient Hospital Care	7.2	5.9	-1.3
Nursing Home Care	5.5	4.4	-1.1
Misc. Professional Care	3.2	1.8	-1.4
Outpatient Hospital Care	11.9	6.0	-5.9

If benefits were based upon actual costs of health care, we would not have a health care "crisis." Health care consumers are insulated by co-pays, deductibles, nondisclosure of prices by hospitals, and fear of posting prices by physicians.

Costs are not the only issue to be concerned about. Innovation, quality and access to care are also important. In a free market world, costs should be controlled while increasing access to better quality products. The United States has "invested" in health care more than other countries. Our investments have paid off by the innovative medications and interventions that have been discovered. The United States has more Nobel Prizes than any other nation. In fact, we have more Nobel awards for Physiology and Medicine than all other countries combined! Many are benefiting from the United States' investment in new technology and medications.

The computer is the best example of the power of free market forces controlling technology costs. Computers are consistently less expensive while the features and options continue to improve. Innovative technology is responsive to free market forces. Health care technology may be more expensive initially but should become progressively less expensive when exposed to market forces.

Liberty Health Group has experienced success in controlling costs in most aspects of health care delivery. Lab tests, surgical procedures, and diagnostic studies are less expensive with transparency and an engaged consumer. When the consumer has knowledge of costs and quality, they make decisions tailored to their preferences. Some may prefer a more expensive option because of better quality or service. Others may prefer less expensive options and save money for future medical needs. Transparency in prices should not be confused with socialism (all prices are the same). In fact, the freedom to charge different prices rewards innovative services.

The ones who suffer the most from hidden costs are the uninsured and underinsured. Hospitals routinely charge 400% more for the uninsured/underinsured. It is impossible to determine what a hospital receives from insurance carriers for comparable visits or procedures. Supposedly, insurance carriers represent large purchasing groups that justify deeper discounts. *42 million uninsured are a significant purchasing group and should be afforded the same discounts as insurance carriers! False scales can never be justified!*

Here is an example of the prices an uninsured individual faced when hospitalized in California. I compared CMAC/ Tricare pricing to the hospital prices. The hospital would not tell what they accepted from other insurance carriers for similar care and services. Our goal - pay an amount accepted from an insurance carrier. The billing department was not cooperative and resisted giving any information.

Lab Tests (code)	**CMAC/Tricare Pricing**	**Hospital Prices**
80053	**$16.09**	**$229**
84484	**$14.98**	**$218**
82805	**$43.19**	**$480**
83520	**$19.70**	**$234**
Summary of some tests	**$229.62**	**$2832**

Procedure Codes	**CMAC/Tricare Pricing**	**Hospital Prices**
CT Scan (71260)	**Global $348.05**	**$2,614**
HHN (94640)	**$12.90 X 31 = $399**	**$125 X 31 = $3875**
ER (99285)	**$149.20**	**$419**
EKG tracing (93005)	**$17.93**	**$329**
Pulse Oximeter (94760)	**$4.75**	**$328**

The discrepancies are glaring and beg an explanation! Our goal was to resolve this matter without legal intervention. Even if the CMAC/Tricare numbers are low, there

cannot be such a wide disparity between the hospital bills and the CMAC/Tricare maximum allowable charge. The hand held nebulizer (HHN) therapy bill and pulse oximeter bills are almost unbelievable! Sadly, this is not an uncommon example.

The notion that hospitals must charge more to make up for the "abuse by the uninsured" is not supported by sound ethical or business discussions. A study by Alwyn Cassil, Center for Studying Health System Change, focused on the frequency of ER visits 1996/97 – 2000/01. They found a 16% increase (108 million/year) in ER visits. Those with insurance or Medicare accounted for 66%. The self-pay or those not charged accounted for 10%. Medicaid/Cash patients reported waiting longer and rated the service they received lower than insured patients. The uninsured were not a major factor for increased crowding in the ER.

It is imperative that hospitals reveal the amount they accept from insurance carriers for a procedure, lab, or service. Mandating they post a price will not resolve the disparity. The result be like the Average Wholesale Price (AWP) used for pharmacy prices, or the shadow that "discounts" create – neither one is practically useful. AWP is a meaningless business term. A 30% "discount" of an inflated price is often worse than 100% payment of a legitimate price.

It is unconscionable to allow this two-tiered billing practice to continue. I have spoken to Hospital Administrators who fear the wrath of the "Medicare Fraud Squad." They are concerned that they cannot accept less than their billed rate from the uninsured/underinsured. A transparent price would eliminate this fear. Furthermore, it does not seem logical to give insurance carriers a price break when they pay their executives multiple million dollar salaries. Sliding scales do not produce transparency.

Liberty Health Group has success with outpatient costs. We have seen progressively less expensive lab tests, diagnostic tests, medication costs controlled, and renewal rates that are consistent with medical inflation (2-4%). New technology and medications will always be more expensive. The individual should be allowed to decide if the more expensive medication is worth the money.

Small businesses are also affected by non-transparent pricing. They are challenged to keep up with premium inflation that is triple medical inflation. Many business owners cannot afford to continue to offer benefits. Mandating coverage does not resolve the problem posed by non-transparent prices.

The Department of Treasury and IRS issued guidance that gave small businesses more leverage in their health benefits options by expanding the use of Health Reimbursement Arrangements (HRA), Section 105 of the Internal Revenue Code (June 2002). The employer credits pre-tax money to their employees that may only be used for qualified medical expenses. Unspent money can accumulate for future medical needs.

Cafeteria plans (Section 125 of the Internal Revenue Code) are similar. The employer and employee can contribute pre-tax money into these accounts for qualified medical expenses. These plans work best for predictable medical expenses. However, unspent money in the Cafeteria plans does not accumulate. As a result, there are end of year spending sprees with the remaining money.

Health Savings Accounts (HSA) are another exciting option. The employer and employee may contribute to these plans that include a pre-tax medical account and a qualified high-deductible policy. In my experience these plans are rich in concept but disappointing in application. The main reasons they are disappointing are: a lack of transparency regarding pricing (HSA holders pay "retail" prices at the doctor and hospital); and renewal rates are disproportionately high after 2-3 years into the plan.

When employees have control of a portion of their health care dollars, they will shop for health care. Preventive services are more likely to be used, less expensive medication options will be pursued, and routine care/immunizations are not neglected.

Legislative efforts that would help control costs, increase access to care, and encourage saving unspent money for unpredictable medical events might focus on the following:

1. Hospitals:
    a. Remove the fear Hospital Administrators have expressed regarding the "Medicare Fraud Squad" evaluating and assessing fines.
    b. Assess non-profit status of hospitals who continue to expect payment from the uninsured that is 400% higher that what is accepted from insurance carriers.
    c. The word "profit" must be defined. There are "for profit" hospitals that are efficient, less expensive than comparable hospitals, and treat all in the ER. Society would be much better served by a "for profit" hospital that posted prices than a non-profit hospital that charges those who need help the most 400% above an acceptable insurance payment.
    d. Something to ponder…Why can hospitals own physicians but physicians cannot own hospitals? Is there ethical superiority of one relationship to the other?

"You must deodorize profit and make people understand that profit is not something offensive, but as important to a company as breathing"

Sir Peter Parker
Chairman, British Rail

"End of year spending sprees by the Federal Government is an egregious waste of tax payer's dollars." …unknown

2. Pharmacy prices:
    a. Disclose rebates and all financial benefits related to pharmacy issues.
    b. Average Wholesale Price (AWP) is a meaningless number for most discussions. The question is rather simple, "What does the drug cost?"
3. Insurance costs: Eliminate restrictions for purchasing health insurance across state borders.
4. Physician fees: Encourage physicians to "post their prices" without fear of fines. I posted my prices since 1997 without any legal problems. Those concerned about a "two-tiered system" must agree that our health care delivery system currently has a "two-tiered system" that favors the insurance carriers and discriminates against the uninsured. This must end!
5.

Transparency issues in health care are vital for the success of any health care delivery system. Costs are controlled, access improved, and innovation appropriately rewarded when prices are transparent and free market forces are allowed to work. I know from the front lines of health care that we could rapidly and dramatically improve health care for the uninsured and underinsured with non-discriminatory, transparent pricing.

"We do not have to see eye to eye to walk hand in hand."

Phillip Gambel

MR. DEAL. No, but you are.
DR. MACDONALD. Well, thanks.

MR. DEAL. What that means is we have got some business on the Floor we may have to attend to in just a minute but thank you, very interesting testimony.

Dr. Collins?

DR. COLLINS. Thank you, Mr. Chairman for this invitation to testify on the importance of making health care cost information publicly available.

MR. DEAL. Would you pull that a little closer, Doctor? There you go.

DR. COLLINS. Transparency and better public information on cost and quality are essential for three reasons: to help providers improve by benchmarking their performance against other providers, to encourage private insurers and public insurance programs to reward quality and efficiency, and to help patients make informed choices about their care. Transparency is also important to level the playing field. The widespread practice of charging patients different prices for the same care is not equitable, especially when the uninsured are charged more than other patients. But it is unreasonable to expect that information on prices, total bills, and quality will cause health care markets to perform like markets for other goods and services. Health care is not homogeneous and patients will never have as much information about the care they need as the physicians who care for them. Health care decisions are made under emergency conditions, emotional stress, and in many occasions both the insurance industry and the health care delivery sector are highly concentrated, leaving patients with few real choices.

As important as price transparency is, price information is of little value by itself. Knowing the prices of health care services is not very helpful when you do not have information on the total cost of caring for a given condition and the quality of the outcomes of that care.

The current state of health care information is inadequate. Patients report that they rarely have cost and quality information available to them. Physicians rarely have comparative information on the quality of their own care or on the quality of the care to physicians to whom they refer patients. Patient use of information, however, is not likely to transform the health care market. Patients are in the weakest position to demand greater quality and efficiency. Payers, Federal and State governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.

Posting a greater financial burden on the sickest and poorest patients through cost sharing and high deductibles is not the right prescription for what currently ails the health care system. Americans already pay far more out of pocket for their health care than citizens in other industrialized countries and people in high deductible health plans either

coupled with health savings accounts or not allocate substantial amounts of their income to their health care. They also are much less satisfied with their care than adults in more comprehensive plans. Most troubling is that people in high deductible plans are far more likely to delay, avoid, or skip health care because of cost. The problem is particularly pronounced among people with low-incomes and health problems. When people in high deductible plans do access care, there is evidence that they are more likely to have problems paying bills and to accumulate medical debt.

So what needs to be done to achieve transparency in our health care system? Medicare should assume a leadership role in making cost and quality information by provider and by patient condition publicly available. It should forge public and private partnerships to create a multi-payer database, uniform quality measures, and transparent methodologies for adjusting quality and cost. As the IOM has recommended, a national quality coordination board within HHS could be created. The board could set priorities, oversee the development of quality and efficiency measures, and ensure the collection of information on those measures. Health information technology should be invested in and fundamental changes in current payment methods should be made. Medicare's physician group demonstration project is a step in the right direction.

HSA health savings account legislation should be modified to reduce its potentially harmful effects on vulnerable populations. Legislative modifications might include permitting lower HSA eligible deductibles for lower wage workers, exempting primary care, as well as preventative services from the deductible, exempting prescription drugs essential for the management of chronic conditions, and guaranteeing choice of a comprehensive plan to workers who are covered under employer plans, permitting greater flexibility and benefit design, and setting an income ceiling on eligibility for HSAs to reduce the tax subsidy for higher income individuals.

Price transparency is the beginning, but it is unlikely to have a major impact in the absence of better information on quality and the total bills for the treatment of various acute and chronic conditions. Creating a database with this information is certainly feasible but it requires Federal leadership. This hearing is an important step towards achieving that outcome.

Thank you.

[The prepared statement of Dr. Sara R. Collins follows:]

PREPARED STATEMENT OF DR. SARA R. COLLINS, SENIOR PROGRAM OFFICER, FUTURE OF HEALTH INSURANCE, THE COMMONWEALTH FUND

TRANSPARENCY IN HEALTH CARE: THE TIME HAS COME

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Invited testimony
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Hearing on "What's The Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs"
March 15, 2006

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TRANSPARENCY IN HEALTH CARE: THE TIME HAS COME

Sara R. Collins, Ph.D.

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the importance of making health care cost information publicly available. Transparency and better public information on cost and quality are essential for three reasons: 1) to help providers improve by benchmarking their performance against others; 2) to encourage private insurers and public programs to reward quality and efficiency; and 3) to help patients make informed choices about their care. Transparency is also important to level the playing field. The widespread practice of charging patients different prices for the same care is inherently inequitable, especially when the uninsured are charged more than other patients.

But it is unreasonable to expect that information on prices, total bills (total costs to patients and insurers), and quality will cause health care market to perform like markets for other goods and services. Health care is not a homogeneous commodity. Patients will never have as much information about the care they need as the physicians who care for them. Health care decisions are often made under emergency conditions and emotional stress. Both the insurance industry and the health care delivery sector are highly concentrated, leaving patients with few genuine choices. In short, all the conditions required for perfectly competitive markets do not exist in health care, making the health care market quite different than markets for other goods and services.

- **Price Information Is of Little Value By Itself**
    - Knowing prices of health care services is of little value without information on the total cost of caring for a given condition and the quality or outcomes of that care.

- **The Current State of Information Is Inadequate**
  - Patients report that they rarely have cost and quality information available to them.
  - Physicians rarely have comparative information on the quality of their own care or on the quality the care of the physicians to whom they refer patients.
- **Patient Use of Information Is Not Likely to Transform Health Care**
  - Patients are in the weakest position to demand greater quality and efficiency.
  - Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.
  - Most health care costs are incurred by very sick patients—patients with heart attacks, strokes, cancer, mental illness, fractures, and injuries—often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances.
- **Higher Patient Cost-Sharing and High-Deductible Health Plans Are the Wrong Prescription**
  - Placing a greater financial burden on the sickest and poorest patients is not the right prescription for what ails the health care system.
  - Americans already pay far more out-of-pocket for their health care than citizens in other industrialized countries that have far lower costs.
  - Few people are currently enrolled in health savings accounts (HSAs) coupled with high-deductible health plans, and those who are enrolled are much less satisfied with many aspects of their health care than adults in more comprehensive plans.
  - People in these plans allocate substantial amounts of income to their health care.
  - Most troubling is that people in high deductible plans are far more likely to delay, avoid, or skip health care because of cost. Problems are particularly pronounced among those with poorer health or lower incomes.

- When people with high-deductible health plans do access health care, there is evidence that they are more likely to have problems paying bills and accumulating medical debt.

What Needs to Be Done

To achieve transparency in our health system, the following steps could be taken:

- Medicare can assume a leadership role in making cost and quality information by provider and by patient condition publicly available. It should forge public-private partnerships to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs.
- Create a National Quality Coordination Board within the U.S. Department of Health and Human Services, as the Institute of Medicine has recommended. The board will set priorities, oversee the development of appropriate quality and efficiency measures, ensure the collection of timely and accurate information on these measures at the individual provider level, and encourage their incorporation in pay-for-performance payment systems operated by Medicare, Medicaid, and private insurers.
- Invest in health information technology, which is essential to ensure the right information is available at the right time to patients, providers, and payers.
- Make fundamental changes in current payment methods. Medicare's physician group practice demonstration is a step in the right direction and should yield valuable insight into whether gains in efficiency and quality can be achieved simultaneously.
- Modify HSA legislation to reduce its potentially harmful effects on vulnerable populations. High-deductible health plans raise the risk that patients will fail to get the early care that could catch serious conditions at an early stage, and fail to get the medications that could control their risk factors and chronic conditions. Legislative modifications to minimize these risks might include:
    - Permit lower HSA eligible deductibles for lower-wage workers
    - Exempt primary care as well as preventive services from the deductible; exempt prescription drugs essential for management of chronic conditions

- Guarantee choice of a comprehensive health plan to workers covered under employer plans
- Permit greater flexibility in benefit design (e.g. actuarially equivalent benefits)
- Set an income ceiling on eligibility for HSAs to reduce the tax subsidy for high-income individuals

Price transparency is a beginning, but it is unlikely to have a major impact in the absence of better information on quality and the total bills for the treatment of various acute and chronic conditions. Creating such a database is certainly feasible but requires federal leadership. This hearing is an important step toward achieving that desirable outcome.

TRANSPARENCY IN HEALTH CARE:
THE TIME HAS COME

Sara R. Collins, Ph.D.

Thank you, Mr. Chairman, for this invitation to testify on the importance of making health care cost information publicly available. Transparency and better public information on cost and quality are essential for three reasons: 1) to help providers improve by benchmarking their performance against others; 2) to encourage private insurers and public programs to reward quality and efficiency; and 3) to help patients make informed choices about their care. Transparency is also important to level the playing field. The widespread practice of charging patients different prices for the same care is inherently inequitable, especially when the uninsured are charged more than other patients, rather than less.

But it is unreasonable to expect that information on prices, total bills (or total cost to patients and insurers), and quality will cause the health care market to perform like markets for other goods and services. Health care is not a homogeneous commodity. Patients will never have as much information about the care they need as the physicians who care for them. Decisions are often made under emergency conditions and emotional stress. Both the insurance industry and the health care delivery sector are highly concentrated, leaving patients with few genuine choices. The way insurers pay for care gives providers powerful financial incentives to perform more and more complex services and procedures. There are a myriad of physicians and other providers involved in an episode of care for a complex or serious condition; patients are not given the choice of anesthesiologist, pathologist, radiologist, or many of the consultants involved in care. No one provider quotes a price for all of the care needed over time for an acute episode, such as a hip replacement, or for a chronic condition that persists over time, such as congestive heart failure. In short, all the conditions required for perfectly competitive markets do not exist in health care, making the health care market quite different than markets for other goods and services.

High-deductible health plans that expose families to high out-of-pocket costs are the wrong prescription for these problems. The purpose of insurance is to ensure that

patients have access to essential care and are not burdened by medical bills. Making patients pay even more for health care undermines the very reason why insurance exists.

Price Information Is of Little Value by Itself

As important as transparency is, knowing prices of health care services is of little value without information on the total cost of caring for a given condition and the quality or outcomes of that care. Health care is not a homogeneous commodity. Patients are not always well advised to seek out the surgeon with the lowest fee, for example. It is important to know the quality of care provided and a surgeon's track record with complications or mortality. Even if a hospital room charge is lower, it's no bargain if the patient is more likely to stay longer or be readmitted for an infection or complication.

Additionally, the price of an individual service is just one element in the total cost that a patient or insurer faces. There is often no standard set of services that are provided to patients with a given condition. The total bill can depend on the tests ordered, the length of the hospital stay, and the number of specialist consultants involved in the care. A surgeon's fee is an important component of the total bill, but so is the anesthesiologist's fee, the radiologist's fee, and the pathologist's fee. One study found that the percentage of patients seeing 10 or more physicians for a hip fracture varied across academic medical centers from 16 percent for those in the lowest quintile to 35 percent for those in the highest quintile (Figure 1).[1] Similar variations occurred over a year's time for patients with colorectal cancer and heart attacks.

Most hospitalized patients have no idea how many physicians will be involved in their care or what their total bills for care, including hospital and physician charges, will amount to. What a patient needs to know is the expected out-of-pocket cost from the beginning to end of treatment, as well as the outcomes of care. For example, for a hip replacement, the patient needs to know expected total bills, including the hospital bill, all physicians' bills (surgeon, anesthesiologist, radiologist, etc.) and bills for follow-up care (physical therapy, medication, follow-up physician visits, etc.). They also need to know the likelihood of complications or infections or need for repeat surgery and how soon

[1] E.S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

they can expect to be pain-free and fully functioning. For a patient with a chronic condition such as congestive heart failure, for example, total bills may include not only an initial hospitalization but a high likelihood of a rehospitalization and multiple physician bills from cardiologists, pathologists, and other physicians, as well as follow-up care such as nurse home visits, medications, and office visits with their physician.

Information needs for insurers include total expected discounted charges over the course of treatment and the value or effectiveness of care. Employers may be interested in knowing how quickly an employee will be able to return to work, which could vary depending on the choice of treatment for a condition such as lower back pain.

Providers are likely to be concerned that information on cost and quality includes an appropriate adjustment for the severity of the patient's condition and any co-morbidities. Providers may also be interested in how the cost and quality of the portion of the care for which they are responsible varies, not just the total bill. And the patient wants to know not only if the operation is likely to be a success, but the likelihood of a hospital-acquired infection as well!

The Current State of Information Is Inadequate

It shouldn't come as a surprise that the information currently available doesn't begin to meet the needs of patients, payers, or providers. Patients report that they rarely have cost and quality information available to them. A national survey of adults by The Employee Benefit Research Institute (EBRI) and The Commonwealth Fund on consumerism in health care found that 14 to 16 percent of insured individuals—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their health plan on quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals (Figure 2).[2] About half of those with the information had tried using it.

Physicians rarely have comparative information on quality of their own care or on the care of the physicians to whom they refer patients. Only one in five physicians report receiving any process or clinical quality-of-care data on their own care, only one in four

[2] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

receive patient survey data, and only one in three receive any kind of quality data (Figure 3).[3] Perhaps even more shocking, only 5 percent of physicians say they always have information on the quality of care rendered by the physicians to whom they refer patients, and nearly two-thirds say they rarely or never have such information (Figure 4).[4]

Pennsylvania is the only state with extensive reporting on hospital charges and quality of care. Hospital charges per patient for the top 27 hospitals with 100 or more heart attack cases ranged from $11,000 to $88,000 in 2003 (Figure 5).[5] Only one hospital had a statistically significant different mortality rate (lower), and its average charge was around $22,000. Yet a patient with a heart attack in Philadelphia is unlikely to ask the ambulance driver to drive two hours to Allentown to have the benefit of its lower charges and better mortality rate. Nonetheless the data could be useful to payers in establishing payment rates—why pay more for poorer care? And it could help hospitals try to understand the best practices that led the Allentown hospital to achieve better results for median cost. But even these data fail to include physician charges—and provide only part of the story.

Data on patients' experiences with hospitals and physicians are just beginning to become available. The Massachusetts Health Quality Partnership and the California Health Care Foundation have piloted releasing patient-reported data on hospital care.[6] The Massachusetts Health Quality Partnership has published clinical quality data on Massachusetts medical groups, and recently released patient-reported data on experiences with physician care at the medical group level, but not at the individual physician level.[7] Integrated HealthCare Association in California similarly has pioneered reporting on patient experiences with care at the medical group level, and its pay-for-performance

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[3] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

[4] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

[5] Pennsylvania Health Care Cost Containment Council, Hospital Performance Results, Hospital discharges between January 1, 2003 and December 31, 2003, www.phc4.org.

[6] See http://www.calhospitalcompare.org/about/index.cfm?itemID=20824; http://www.mhqp.org/.

[7] The Commonwealth Fund, *Quality Matters:* Public Reporting of Physician Group Quality Data, February 2006, Vol. 16; Massachusetts Health Quality Partnership, "Landmark Report Provides Massachusetts Consumers Comprehensive Information on Quality of Care Based on Patients' Experiences," March 9, 2006.

schemes often reward medical groups for both high performance on clinical quality indicators and on patient experiences with care.[8] These are important path-breaking efforts—but, again, far from standard practice.

Medicare has lagged behind these private sector efforts, but is beginning to actively collect quality information. The Medicare Modernization Act and the Deficit Reduction Act reduce Medicare payment rates to hospitals by 0.4 percent and 2.0 percent respectively for those not "voluntarily" reporting selected hospital quality indicators. As a result, nearly all hospitals now submit the required information. A study supported by The Commonwealth Fund and published in the *New England Journal of Medicine* found wide variation in the Medicare hospital quality indicator data across hospitals and geographic areas (Figure 6).[9] Further, hospitals scoring highly on quality of care for heart attack patients typically did not score highly on quality of care for pneumonia patients—suggesting the difficulty of establishing networks of providers that patients can reliably expect to provide high-quality care regardless of the reason for which they are hospitalized. These data are potentially helpful, however, in helping all hospitals learn best practices that lead to superior results.[10] Medicare has also begun to ask physicians to submit quality data voluntarily.

Because Medicare has more than 40 million beneficiaries, its claims data are potentially valuable in profiling individual providers' quality and efficiency. Medicare should make publicly available total hospital and physician standardized charges over the course of treatment for patients with different health conditions and with different hospital or medical groups involved in their care. It should also join with private insurers in creating a multi-payer database that could be used for this purpose.

The federal Agency for Healthcare Research and Quality collects data on hospital cost, quality, and patient safety in 36 states under its Health Care Utilization Project. However, because of the data agreements with states and hospitals, these data aren't available publicly by name of hospital, or even by identified state.

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[8] See http://www.iha.org.

[9] A.K. Jha, Z. Li, E.J. Orav and A.M. Epstein, "Care in U.S. Hospitals—The Hospital Quality Alliance Program," *New England Journal of Medicine* 353 (July 21, 2005): 265–74.

[10] The Commonwealth Fund, *Quality Matters:* Performance Matters, December 2005, Vol. 14, Sheree Crute, "Case Study: Achieving High-Quality Care at Reid Hospital and Health Care Services."

Specialty societies are also starting to collect quality information but, again, this information is rarely in the public domain. Patients could benefit greatly by knowing five-year survival rates for different kinds of cancer by cancer center, and complications of cardiac surgery by hospital and surgical team.

Private insurers have started classifying providers by quality and costs, but their methods for doing so are not transparent and are often proprietary. Furthermore, most private insurers have too few patients with a given condition obtaining care from a given physician to create reliable quality and efficiency metrics. This is further complicated, fortunately, by the relatively low rate of complications (such as wrong site surgery). Even states like New York and Pennsylvania that report on cardiac surgery mortality are often differentiating hospitals with a 4 percent mortality from those with a 2 percent mortality. To accurately capture such variations in quality, a database on all patients, including those covered by Medicare, Medicaid, and private insurers, is needed.

The science of measuring quality and patient experiences with care has advanced considerably in the last decade, although the data are not routinely collected and made publicly available at the individual provider level. The science of measuring efficiency at the individual provider level with appropriate adjustment for patient complexity and other factors is somewhat less advanced.

But perhaps the greatest barrier to generating the kind of information that is needed is the resistance of providers to making quality information available. A Commonwealth Fund survey of physicians and quality of care in 2003 found that one-fourth of physicians would definitely or probably not be willing to make their own quality information available to the medical leadership of their organization or to other physicians; two in five would not make this information available to their own patients; and two- thirds definitely or probably would not make them available to the general public (Figure 7).[11] Similarly, in a Commonwealth Fund international survey in 2003, one-third of hospital CEOs in the U.S. indicated that information on mortality rates,

[11] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

medical errors, and nosocomial infection rates should not be released to the public (Figure 8).[12]

Even the most optimistic estimate is that it will be 5 to 10 years before systematic information on quality and cost is available to all parties—and then only if the federal government, especially Medicare, demonstrates far greater leadership in creating the kinds of information databases necessary. The Institute of Medicine recently released a report, *Performance Measurement,* in response to a Congressional request that called for creation of a National Quality Coordination Board to approve quality measures and ensure creation of timely databases, among other things.[13]

Patient Use of Information Is Not Likely to Transform Health Care

It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care system will be driven by patient choice of provider. Patients are in the weakest position to demand greater quality and efficiency. By contrast, payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance. Most health care costs are incurred by very sick patients—patients with heart attacks, strokes, cancer, mental illness, fractures, and injuries—often under emergency conditions. Ten percent of the sickest patients account for about 70 percent of all health care spending (Figure 9).[14] Shopping for the best physician or hospital is impractical in such circumstances.

Nor are patients accustomed to seeking such information or trusting the information that is available. The Employee Benefit Research Institute and Commonwealth Fund 2005 survey of consumerism found that the most trusted source of information is the patient's own physician (Figure 10). The least trusted sources of information are health plans and government agencies—with only about 1 in 20 trusting

[12] R.J. Blendon, C. Schoen, C.M. DesRoches, R. Osborn, K. Zapert and E. Raleigh, "Confronting Competing Demands To Improve Quality: A Five Country Survey," *Health Affairs* 2004 23(3):119-135.

[13] Institute of Medicine, *Performance Measurement: Accelerating Improvement*, National Academies Press, Washington, DC: December 2005.

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

those sources of information. Yet health plans and government agencies are far more likely to be able to assemble the required information.

Still, studies fairly systematically find that public information on quality is not used by patients. New York and Pennsylvania were pioneers in publishing information on cardiac surgery mortality by name of surgeon and hospital, yet few patients avail themselves of this information.[15] The information was valuable because hospital CEOs investigated the reasons for poor performance and took necessary action—not because patients voted with their feet.[16]

Provider response to public information is, in fact, one of the strongest arguments for public reporting. The National Committee for Quality Assurance has found that those managed care plans that report their quality data publicly are more likely to improve.[17] Hospitals who report quality information take steps to improve quality.[18] And a recent study found that the top-performing medical groups were those that reported quality data publicly—either voluntarily or because of local reporting requirements.[19]

Higher Patient Cost-Sharing Is the Wrong Prescription

Increasing patient cost-sharing is the wrong prescription for reining in U.S. health care costs. Americans already pay far more out-of-pocket for their health care than citizens in any other industrialized country (Figure 11).[20] In addition, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 12).[21] Higher

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[15] M.N. Marshall, P.G. Shekelle, S. Leatherman and R.H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (April 2000): 1866 - 1874.

[16] M.N. Marshall, P.G. Shekelle, S. Leatherman and R.H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (April 2000): 1866 - 1874.

[17] National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005).

[18] J.H. Hibbard, J. Stockard and M. Tusler, "Hospital Performance Reports: Impact on Quality, Market Share, and Reputation: Evidence from a Controlled Experiment," *Health Affairs*, July/August 2005 24(4):1150-60; J.H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Public Stimulate Quality Improvement Efforts?" *Health Affairs*, March/April 2003 22(2):84-94.

[19] S.M. Shortell, J. Schmittdiel, M.C. Wang et al., "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study," *Medical Care Research and Review* 62, no. 4 (August 2005): 407-434.

[20] B.K. Frogner and G.F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Forthcoming.

[21] C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (January/February 2006).

spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their incomes on medical costs. A recent Commonwealth Fund report by Mark Merlis found that the percentage of households spending 10 percent or more of their income on out-of-pocket costs rose from 8 percent during the years 1996–97 to 11 percent in 2001–02 (Figure 13).[22] Including premiums, 18 percent of all families spent more than 10 percent of income on health care.

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care that they need. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less essential health care.[23] Similarly, a study by Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and non-essential drugs and increased the risk of adverse health events (Figure 14).[24] Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found that insured people with out-of-pocket costs that were high relative to their incomes were nearly as likely to report not accessing health care because of costs as were people without coverage at all.[25]

High-Deductible Health Plans and Health Savings Accounts

Proponents of health savings accounts (HSAs) coupled with high deductible health plans (HDHPs) say these plans make people better consumers of health care by giving them greater responsibility for the costs of their care. The Medicare Modernization Act of 2003 allowed people with HDHPs (now $1,050 for an individual and $2,100 for a family) to open an HSA into which they can contribute pre-tax dollars with the deductible amount not to exceed $2,600 for an individual or $5,200 for a family. Employers can also contribute up to the full amount of the cap.

Low enrollment so far. Consumer-driven health plans, as these plans have become known, have received considerable attention in the press. Yet few Americans

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[22] M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.

[23] J.P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, November/December 2004.

[24] R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.

[25] C. Schoen, M.M. Doty, S.R. Collins and A.L. Holmgren, "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289–W5-302.

have enrolled in them to date. The EBRI/Commonwealth Fund Consumerism in Health Care Survey found that as of October 2005, just 1 percent of the adult population had a HDHP and an HSA or health reimbursement arrangement (HRA) (Figure 15).[26] An additional 9 percent had an HSA-eligible HDHP but had not yet opted to open an account. Other studies have found similarly low levels of enrollment. The General Accountability Office found that as of March 2005, only 7,500 federal employees, retirees, and dependents out of 9 million covered lives had opted to enroll in the HDHP/HSA product offered by the Federal Employee Health Benefits Program (Figure 16).[27] A recent study by America's Health Insurance Plans estimates that there are currently about 3 million people enrolled in consumer-driven plans.[28]

Reflecting the fact that those in higher income tax brackets have the greatest tax benefits associated with HSAs, as the uncovered first dollar expenses, the plans have disproportionately attracted people with higher incomes and those who are in better health (Figures 17-18).[29] Unlike federal employees, most people who are enrolled in the plans did not have a choice. The EBRI/Commonwealth Fund survey found that less than half of those enrolled in the plans through an employer had a choice of plan (Figure 19).[30]

Low satisfaction. Among the small number of Americans who do have these plans, few are satisfied with them. The EBRI/Commonwealth Fund survey found that people with HDHPs both with and without HSAs were far more likely than people in more comprehensive plans to report dissatisfaction with several aspects of their health care including quality of care, out-of-pocket costs, and overall satisfaction with their

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[26] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005.

[27] Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf.

[28] CQHealthBeat, "Ignagni: "Young Immortals Aren't Dominating HSA Enrollment," March 9, 2006.

[29] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005; General Accounting Office, 2006.

[30] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005.

plans (Figures 20-23)[31]. Moreover, one-third of those in the plans would change plans if they had the opportunity to do so and only one-third or less would recommend the plan to a friend or co-worker (Figures 24-25).

High out-of-pocket costs. The high rates of dissatisfaction with the costs of consumer-driven plans likely stem from the substantial amount of income people in these plans allocate to their health care, particularly those with health problems or who are in households with lower incomes. The EBRI/Commonwealth Fund survey found that two-thirds of adults enrolled in a HDHP with an HSA or HRA with incomes of less than $50,000 spent 5 percent or more of their income on out-of-pocket costs and premiums, twice the rate of those with similar incomes in more comprehensive plans (Figure 26).

Cost-related access problems. The early experience with these plans reveals that their high deductibles are leading many enrollees to delay, avoid, or skip health care. The EBRI/Commonwealth Fund survey found that one-third of those in HDHPs with and without HSAs had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans (Figure 27). People with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults in consumer-driven plans with incomes of less than $50,000 reported delaying or avoiding care; this is rate is also nearly twice that of people in the same income group in more comprehensive plans. Similarly, people enrolled in high-deductible plans were more likely to skip doses of their medications to make them last longer or not fill their prescriptions at all; the rates of skipped medication were highest among people with health problems (Figures 28-29).

Risk of medical debt. When people with high-deductible health plans do access health care, they are at risk of accumulating medical debt. Karen Davis and colleagues examined data from the Commonwealth Fund Biennial Health Insurance Survey (2003) and found that adults with deductibles of more than $500 were more likely than those in lower deductible plans to report problems paying medical bills or that they were paying

[31] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005.

off medical debt over time (Figure 30).[32] Medical bill problems included not being able to pay bills, being contacted by a collection agency about medical bills, or having to change your way of life in order to pay bills.

Lower savings for retirement. Other research has found that rising out-of-pocket costs are reducing people's ability to save for retirement. The 2005 EBRI Health Confidence Survey found that 29 percent of adults under age 65 with health insurance reported that they financed increased health care spending by using up all or most of their savings.[33]

HSAs will not solve the uninsured problem. The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people who are uninsured. In 2004, nearly 46 million people were without health insurance, an increase of 6 million over 2000.[34] Research by Sherry Glied and Dahlia Remler found that the tax benefits of HSAs would lower the number of uninsured by fewer than 1 million people. This is because 55 percent of those who are currently uninsured earn incomes that are so low that they pay no income tax and an additional 16 percent fall in the 10 percent tax bracket (Figure 31).[35]

What Needs to Be Done

The Committee is to be commended for focusing the nation's attention on the need for transparency in health care. The absence of public information on cost and quality at the individual provider level is undermining efforts to achieve a high performance health system. Better information benefits everyone. It helps patients know what to expect and become more active and engaged partners in their care. It helps providers know where their performance falls short and how it might be improved. It helps private insurers and public programs align financial incentives in a way that rewards higher quality and efficiency.

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[32] K. Davis, M.M. Doty and A. Ho., *How High is Too High? Implications of High Deductible Health Plans* (New York: The Commonwealth Fund) April 2005.

[33] R. Helman and P. Fronstin, "2005 Health Confidence Survey: Cost and Quality Not Linked," EBRI Notes (Washington, DC: *EBRI*), November 2005, Vol 26, No 11.

[34] C. DeNavas-Walt, B.D. Proctor, C.H.Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports (Washington, D.C.: U.S. Census Bureau) August 2005.

[35] S.A. Glied and D.K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage* (New York: The Commonwealth Fund) April 2005.

To achieve transparency in our health system, Medicare needs to take a leadership role in making cost and quality information by provider and by patient condition publicly available. Medicare should also forge public-private partnerships to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs. This may require legislative authorization with a realistic timetable.

Multiple conflicting quality metrics used by different parties, however, have the potential to add to administrative burden on providers. The Institute of Medicine has called for creation of a National Quality Coordination Board located within the U.S. Department of Health and Human Services to set priorities, oversee the development of appropriate quality and efficiency measures, ensure the collection of timely and accurate information on these measures at the individual provider level, and encourage their incorporation in pay-for-performance payment systems operated by Medicare, Medicaid, and private insurers.[36]

Investment in health information technology is essential to ensure the right information is available at the right time to patients, providers, and payers. While many have called for such change, the current state of affairs is inadequate. Only about one in four physicians have electronic medical records, demonstrating that the benefits of modern information technology (IT) are far from being realized.[37] Some private insurers have begun to build rewards for IT into their payment systems. Medicare and Medicaid should consider doing the same, at least on an initial basis to encourage the adoption and utilization of IT.

Armed with the right information, patients can contribute in a small way to better care by getting regular preventive care, becoming educated about the risks and benefits of elective procedures, sharing medical history with multiple providers helping to coordinate care and reduce waste and duplication of tests. But placing greater financial burdens on the sickest and poorest patients is not the right prescription for what ails the health care system. High-deductible health plans run the risk that patients will fail to get the early care that could catch serious conditions at an early stage, and fail to get the

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[36] Institute of Medicine, *Performance Measurement: Accelerating Improvement*, National Academies Press, Washington, DC: December 2005.

[37] A-M. Audet, M. Doty, J. Peugh, J. Shamasdin, K. Zapert and S. Schoenbaum, "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine,* December 7, 2004

medications that could control their risk factors and chronic conditions. It is important that modifications be made to the health savings accounts legislation to reduce potentially harmful effects on these vulnerable populations. These might include:

- Permit employers to lower deductibles for lower-wage workers and qualify for HSAs
- Exempt primary care as well as preventive services from the deductible; exempt prescription drugs essential for management of chronic conditions
- Guarantee choice of a comprehensive health plan to workers covered under employer plans
- Permit greater flexibility in benefit design (e.g. actuarially equivalent benefits)
- Set an income ceiling on eligibility for HSAs to reduce the tax subsidy for high income individuals

Health care costs are high because of the fragmented way we organize and deliver health care, and because we provide the wrong financial incentives to hospitals and doctors. If we want to transform the health care system, we will need to make fundamental changes in current payment methods. Medicare's physician group practice demonstration (Figure 32) is a step in the right direction and should yield valuable insight into whether gains in efficiency and quality can be achieved simultaneously. Some state Medicaid programs, particularly Rhode Island's RIte care (Figure 33), have had excellent results in both slowing the rate of increase in premiums and improving quality.[38] A Fund-supported evaluation of the PacifiCare pay–for-performance initiative in California also found promising results.[39] Yet, these programs are just the beginning, and Medicare, Medicaid, and private payers need to do much more to change financial incentives for providers so that they systematically reward high quality and efficiency.

But we will never have a high functioning health care system when we have an unprecedented number of Americans without adequate health insurance coverage. Health care needs to be made more affordable–not less affordable—for patients. We need to

[38] S. Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*, The Commonwealth Fund, January 2003.

[39] M.B. Rosenthal, R.G. Frank, Z. Li et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *Journal of the American Medical Association,* October 12, 2005, 294 (14): 1788–93.

cover the nation's 46 million uninsured, building on what works. Particularly promising are strategies to expand employer-based coverage, eliminate the two-year waiting period for coverage of the disabled under Medicare, let older adults buy-into Medicare, and build on state Children's Health Insurance Program to cover low-income parents and other adults.[40]

In many cases, patient cost-sharing is far too high and deters access to needed care. Approximately 16 million adults in the U.S. are underinsured, and report both difficulty obtaining needed care and heavy financial burdens.[41] Rather than insisting on minimum high deductibles at $2100 per family, our nation's health policy should be geared toward setting maximum limits on family cost-sharing, e.g. 5 percent of income for those in the lower tax brackets and ten percent of income for those with higher income. Guaranteeing affordability of care for all Americans will help ensure that patients receive appropriate preventive care, detect serious conditions in early stages, and control chronic conditions that would otherwise undermine health and functioning and lead to higher costs later in life.

Price transparency is a beginning, but is unlikely to have a major impact without better information on quality and total bills for the treatment of different acute and chronic conditions. Creating such a database is certainly feasible but requires federal leadership. This hearing is an important step toward achieving that desirable outcome.

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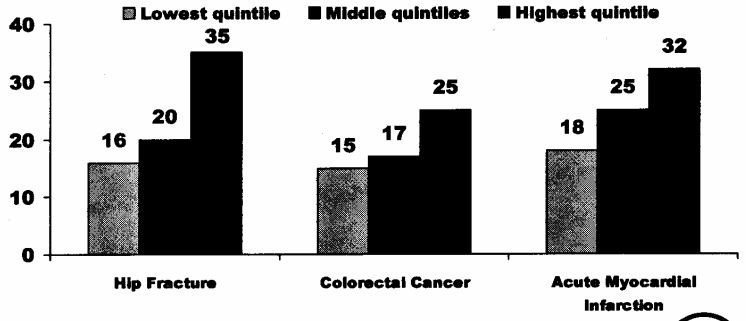
[40] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, April 23, 2003.

[41] C. Schoen, M.M. Doty, S.R. Collins and A.L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005, W5-289–W5-302.

Figure 1. Percent of Patients Seen by 10 or More Physicians Varies Across Academic Medical Centers

Average percentage of patients seeing 10+ different physicians in first year of care within AMC hospitals



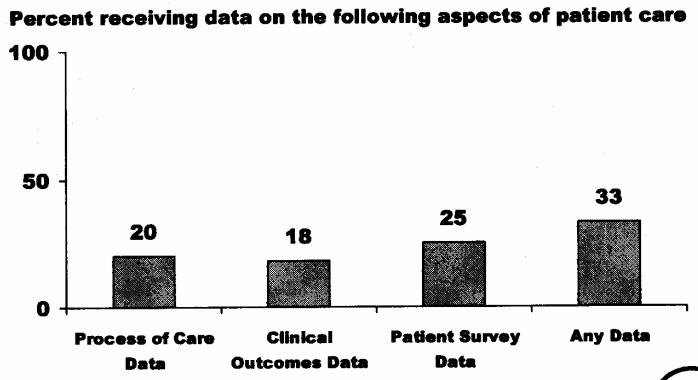
Note: Quintiles of practice intensity ("treatment groups") corresponded closely to regional differences in price and to illness-adjusted Medicare spending.
Source: E.S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

Figure 2. Private-Public Collaboration Needed to Improve Availability of Quality and Cost Information

	Comprehensive	HDHP/CDHP
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36 (n = 76)
Hospitals	14	32 (n = 76)

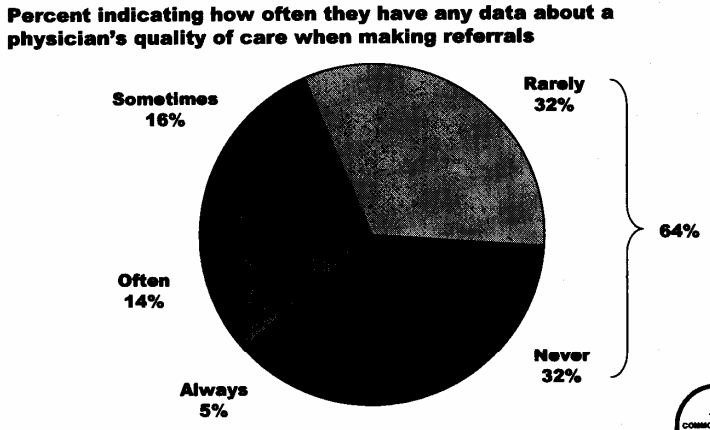
Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.

Figure 3. Physicians' Access to Quality-of-Care or Performance Data on Their Own Care



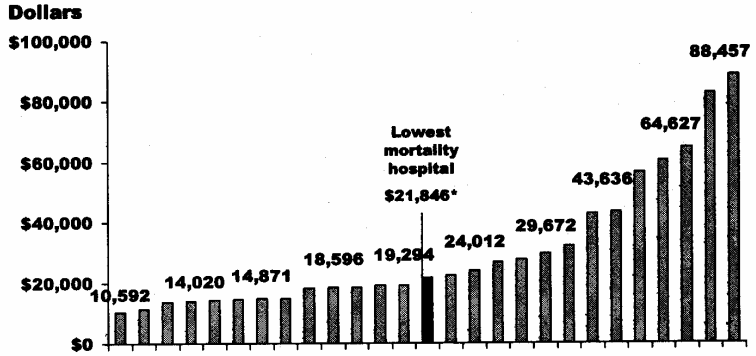
Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

Figure 4. Availability of Quality-of-Care Data When Making Referrals



Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

Figure 5. Hospital Charges for AMI–Medical Management Vary Eight-Fold Across Large Pennsylvania Hospitals



*This hospital demonstrated significantly lower than expected in-hospital mortality rates.
Note: Hospital charge equals patient total charge excluding professional fees; all hospitals shown provided advanced cardiac services (angioplasty/stent procedures), had >100 cases, and <5% of cases transferred to another acute care facility.
Source: Pennsylvania Health Care Cost Containment Council, Hospital Performance Results, Hospital discharges between January 1, 2003 and December 31, 2003, www.phc4.org.

Figure 6. Top-Ranked and Bottom-Ranked Performances in Measures of Quality of Care for AMI, CHF, and Pneumonia Among the 40 Largest Hospital-Referral Regions*

Hospital-Referral Region	AMI Score (%)	Hospital-Referral Region	CHF Score (%)	Hospital-Referral Region	Pneumonia Score (%)
Top-ranked		**Top-ranked**		**Top-ranked**	
Boston, MA	95	Boston, MA	89	Oklahoma City, OK	82
Minneapolis, MN	94	Detroit, MI	88	Indianapolis, IN	79
Kansas City, MO	94	Baltimore, MD	87	Kansas City, MO	78
Albany, NY	93	Camden, NJ	87	Camden, NJ	78
Indianapolis, IN	92	Cleveland, OH	86	Knoxville, TN	77
Bottom-ranked		**Bottom-ranked**		**Bottom-ranked**	
Little Rock, AK	86	San Diego, CA	77	Miami, FL	63
Orlando, FL	86	Nashville, TN	76	Chicago, IL	61
Miami, FL	85	Orlando, FL	74	San Diego, CA	60
Memphis, TN	84	Little Rock, AK	69	Los Angeles, CA	60
San Bernardino, CA	83	Lexington, KY	68	San Bernardino, CA	59

*AMI denotes acute myocardial infarction, and CHF congestive heart failure.
Source: A K. Jha, Z. Li, E. J. Orav, and A. M. Epstein, "Care in U.S. Hospitals—The Hospital Quality Alliance Program," *New England Journal of Medicine* 353 (July 21, 2005): 265–74.

Figure 7. Physicians' Willingness to Share Quality-of-Care Data

Willingness to share data with:*	Yes, Definitely/ Probably	No, Definitely/ Probably Not
Medical leadership	71%	27%
Physicians' own patients	55%	44%
General public	29%	69%
Other physicians	72%	26%

*Answers to survey question: "To improve high quality of care in the U.S., which of the following do you think should have access to 'Quality of Care' data about individual physicians?"
Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

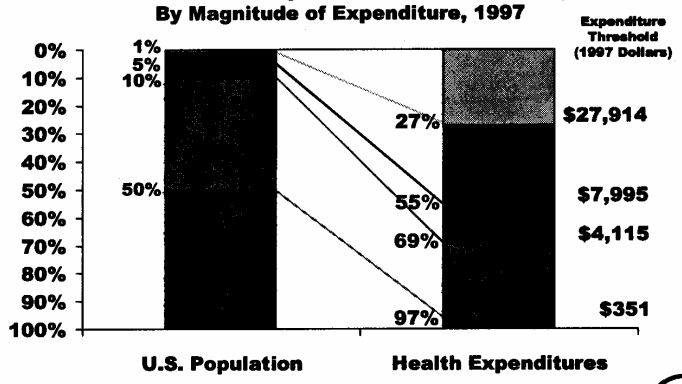
Figure 8. Hospital CEO Opposition to Disclosure of Quality Information to the Public

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

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

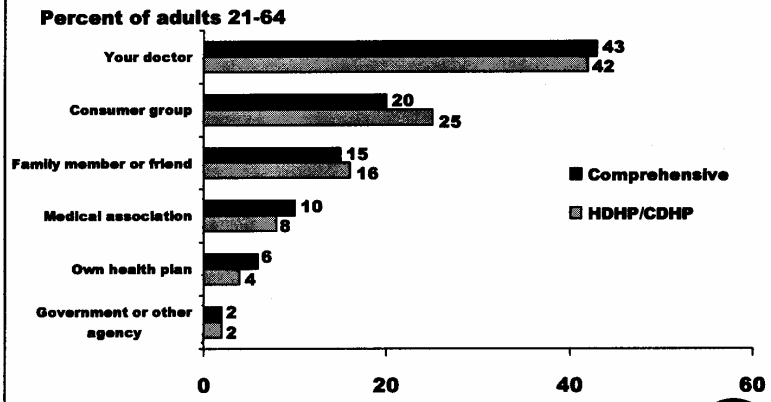
Figure 9. Most Costs Are Concentrated in the Very Sick

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



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

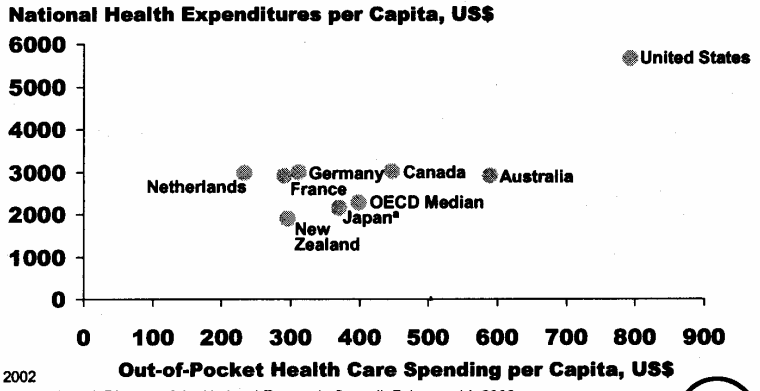
Figure 10. Most Trusted Sources for Information on Health Care Providers, by Insurance Source



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

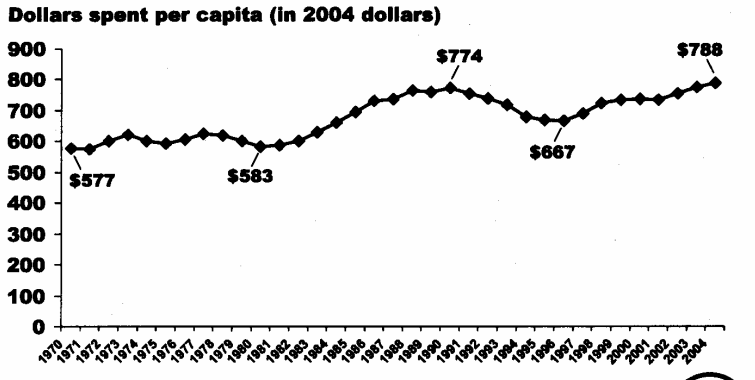
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 11. "Perception that Health Care Is Free"* Is Not the Problem



[a] 2002
*Allan Hubbard, Director of the National Economic Council, February 14, 2006.
Note: Adjusted for Differences in the Cost of Living, 2003.
Source: Bianca K. Frogner and Gerard F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Forthcoming.

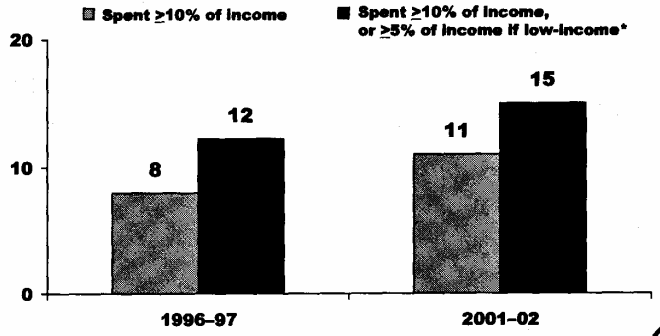
Figure 12. Consumers Spending More Out-of-Pocket for Health Care



Source: C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (January/February 2006); Centers for Medicare and Medicaid Services, National Health Expenditures Data; http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

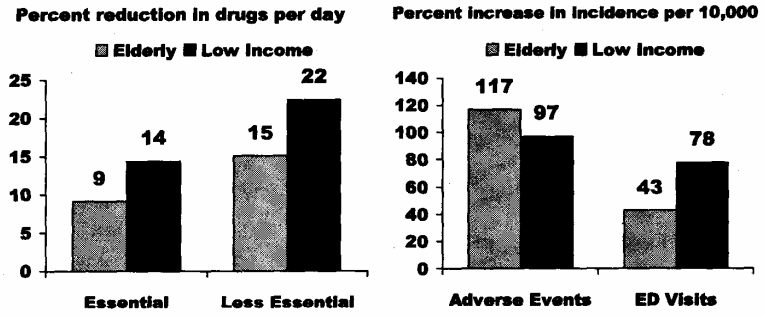
Figure 13. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001–02

Percent of families with high out-of-pocket medical costs relative to income, *not* including premiums



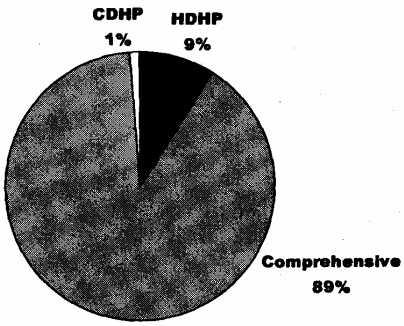
*Low-income includes families with incomes <200% of the federal poverty level.
Source: M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.

Figure 14. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



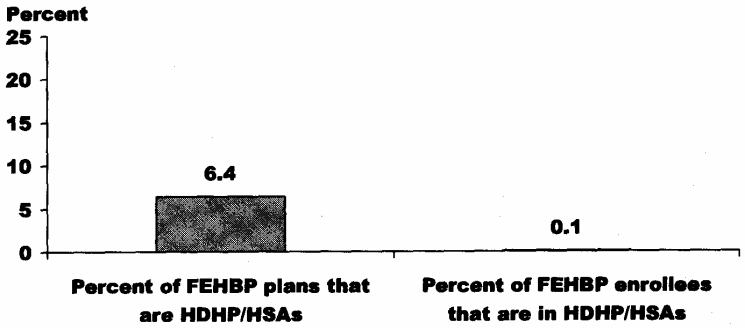
Source: R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.

Figure 15. Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan



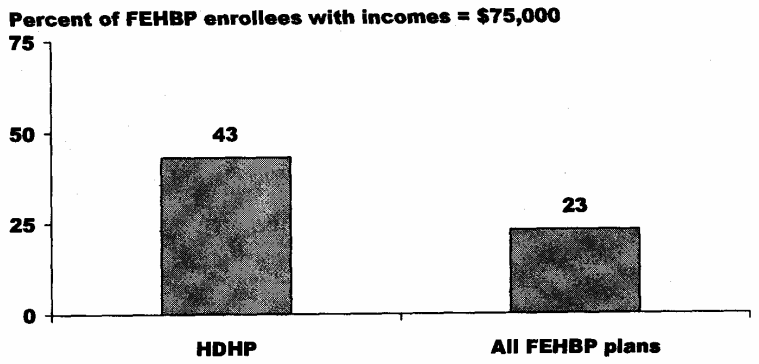
Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 16. FEHBP HDHP/HSAs Plans Enroll 7,500 out of 9 Million Covered Lives



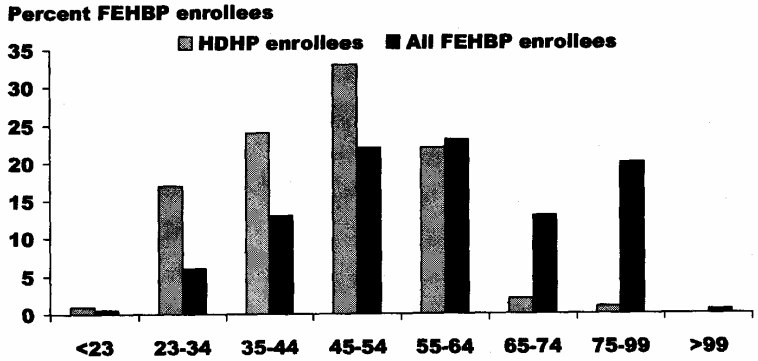
Note: As of March 2005.
Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf

Figure 17. Enrollees Who Chose HDHPs from the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes



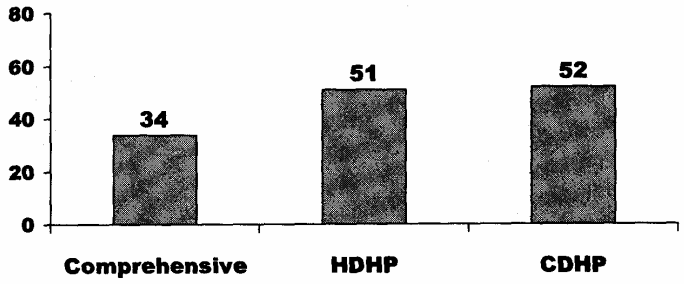
Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006.

Figure 18. Age Distribution of HDHP and Other FEHBP Enrollees



Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006.

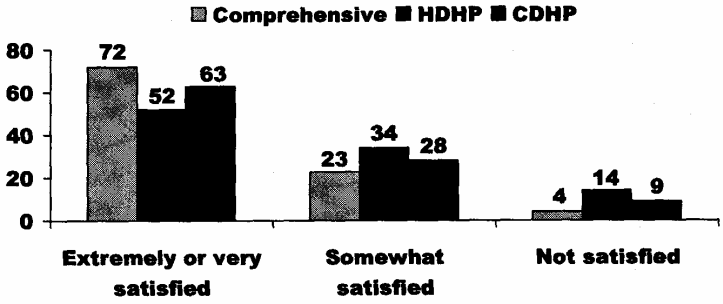
Figure 19. Percentage of Individuals Covered by Employment-Based Health Benefits With No Choice of Health Plan, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

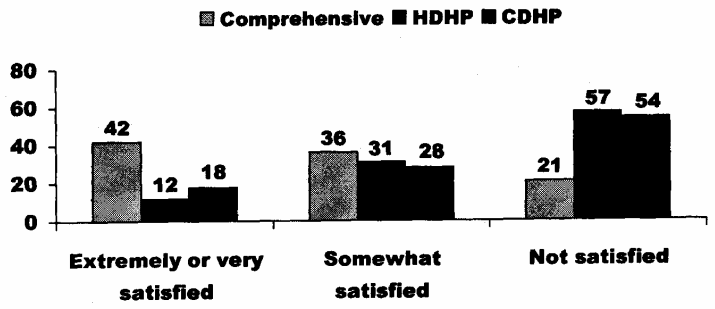
Figure 20. Satisfaction with Quality of Health Care Received, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

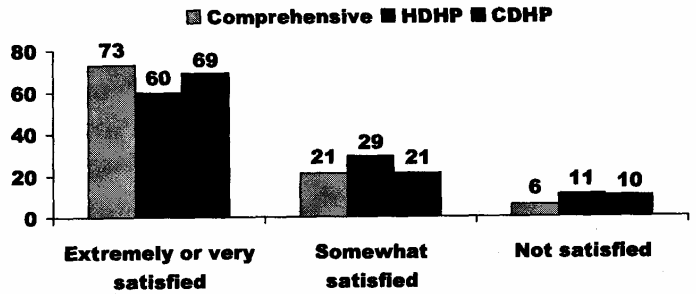
Figure 21. Satisfaction with Out-of-Pocket Costs for Health Care, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

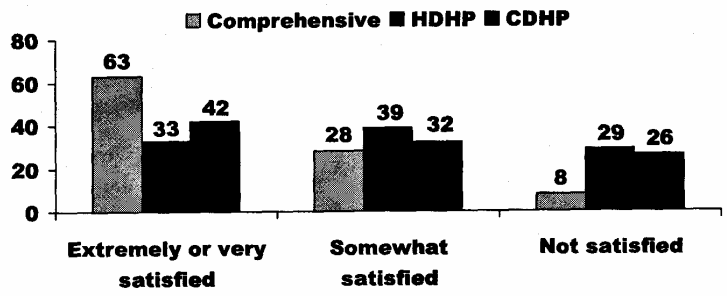
Figure 22. Satisfaction with Choice of Doctors, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

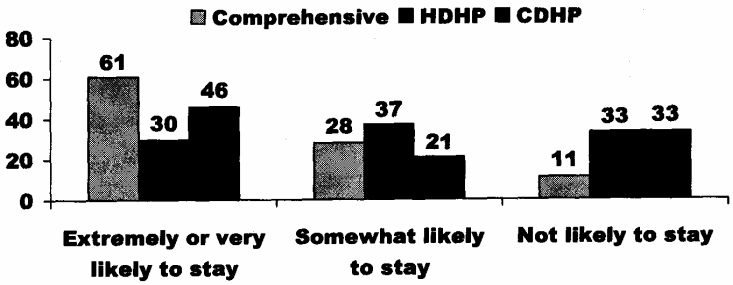
Figure 23. Overall Satisfaction with Health Plan, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

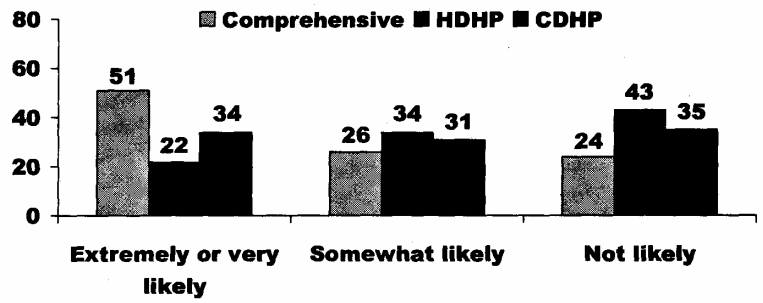
Figure 24. Likelihood of Staying With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 25. Likelihood of Recommending Health Plan to Friend or Co-Worker, by Type of Health Plan

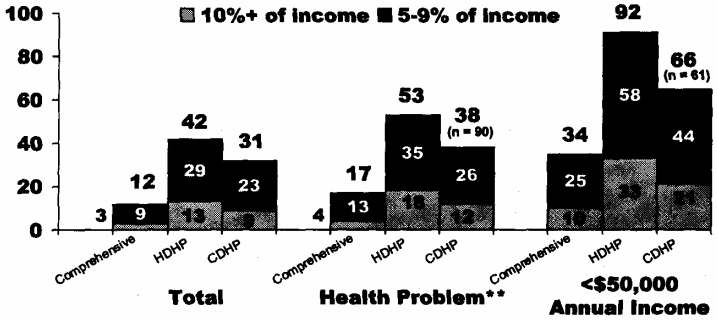


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 26. Percent of Income Spent Annually on Out-of-Pocket Medical Expenses, Including Premiums

Percent of adults 21-64 spending = 5% of income



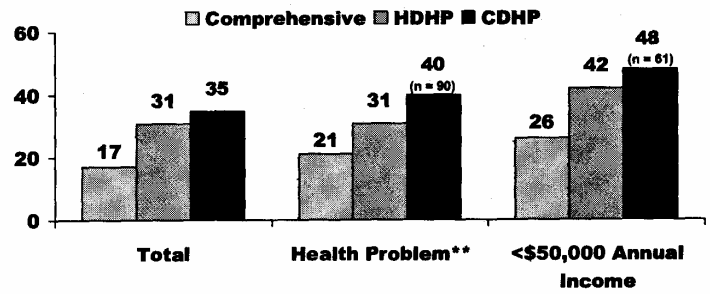
Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 27. Percent of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost

Percent of adults 21-64



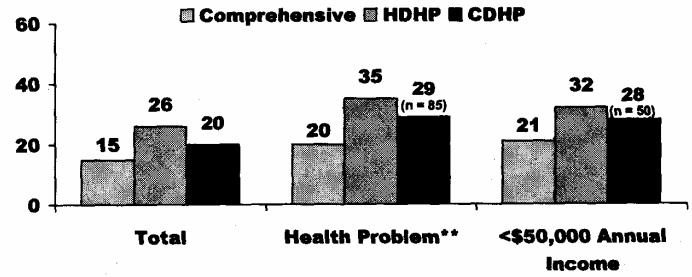
Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 28. Percent of Adults Who Have Skipped Doses to Make a Medication Last Longer

Percent of adults 21-64 with prescriptions in last twelve months

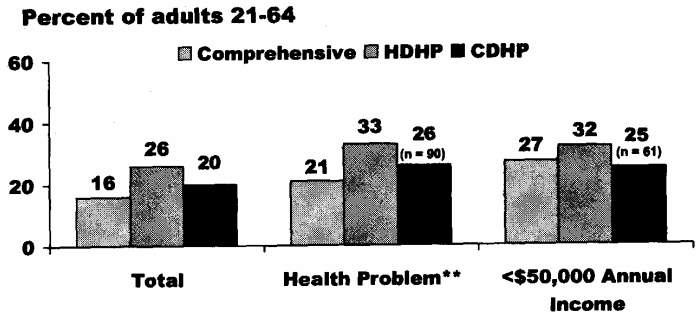


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 29. Percent of Adults Who Have Not Filled a Prescription Due to Cost

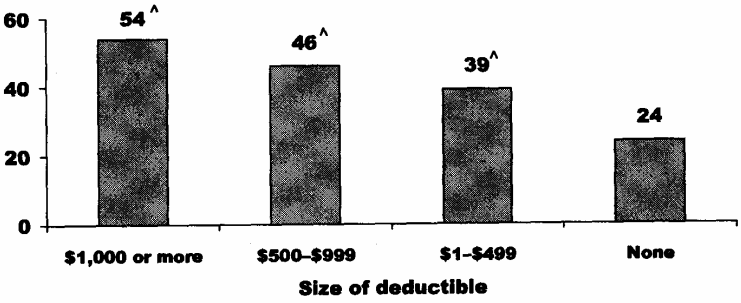


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 30. Medical Bill or Debt Problems in Past Year, by Size of Deductible



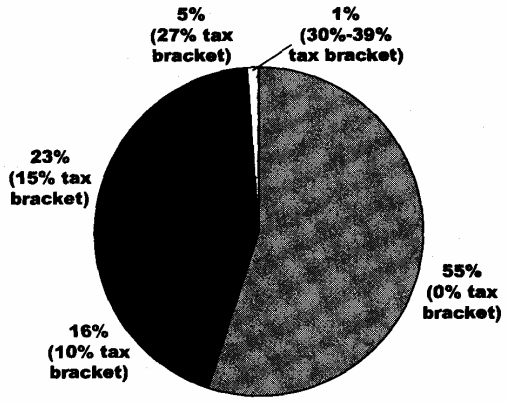
Note: Adjusted percentages based on logistic regression models; controlling for health status and income.

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

^Significant difference at $p < .05$ or better; referent category = no deductible.

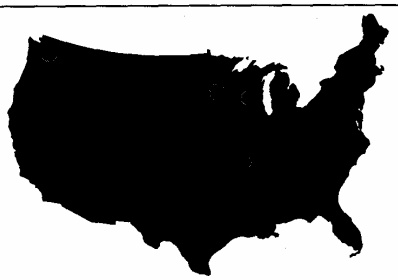
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Figure 31. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured



Source: S.A. Glied, *The Effect of Health Savings Accounts on Health Insurance Coverage*, The Commonwealth Fund, April 2005.

Figure 32. Medicare Physician Group Practice Demonstration

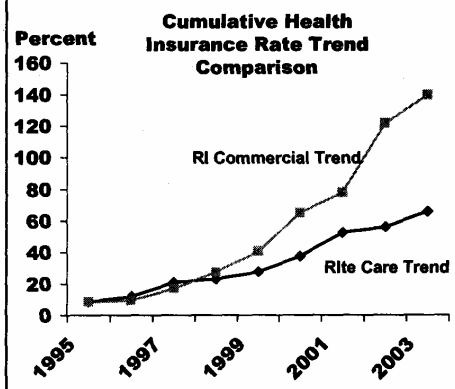


- The Everett Clinic (WA)
- Deaconess Billings Clinic
- Park Nicollet Health Services (MN)
- Marshfield Clinic (WI)
- St. John's Health System (MO)
- Univ. of Michigan Faculty Group Practice
- Geisinger Health System (PA)
- Forsyth Medical (NC)
- Middlesex Health (CN)
- Dartmouth-Hitchcock Clinic

- 10 physician group practices
- 3-year project, began April 2005
- Bonus pool based on savings relative to local area
- Practices expected to save 2%, keep up to 80% of additional savings
- Actual bonuses depend on savings and quality targets

Source: "Medicare Physician Group Practice Demonstration," www.cms.gov, January 31, 2005.

Figure 33. Building Quality Into RIte Care
Higher Quality and Improved Cost Trends



- **Quality targets and $ incentives**
- **Improved access, medical home**
  - **One third reduction in hospital and ER**
  - **Tripled primary care doctors**
  - **Doubled clinic visits**
- **Significant improvements in prenatal care, birth spacing, lead paint, infant mortality, preventive care**

Source: Silow-Carroll, *Building Quality into RIte Care*, Commonwealth Fund, 2003. Tricia Leddy, *Outcome Update*, Presentation at Princeton Conference, May 20, 2005.

MR. DEAL. Thank you, Dr. Collins.

I am going to try to get both of you in before we have to break for a series of three votes and as you know that would take us a little while to get back. So Dr. Goodman, we will proceed with you now.

MR. GOODMAN. Thank you, Mr. Chairman and members of the committee.

Will we some day be able to buy health care the way we buy groceries? Some people think that day is coming but before our consumers can be savvy shoppers in the medical marketplace, they must have information about prices and quality and must be able to compare prices and compare value.

A recent Harris Poll found that Americans could guess the price of a new Honda within $300 of the actual price, but when asked to guess the price of the cost of four days in the hospital, they were off on average by $8,000.

Now some have suggested in this hearing that we need new legislation, but I would say before we legislate, we should stop and ask why are we having this problem in the first place? It is not normal for sellers to hide their prices. In normal marketplaces the sellers advertise prices, they attract buyers by offering discounts. So what is it that is so different about the medical marketplace? I would suggest to you that the big overriding difference is that decade after decade, going back almost 100 years, we have various institutions actively suppressing normal market forces. And so today we are living with the effects of 100 years of, in my opinion, unwise legislation.

Doctors today primarily do not compete with each other on the basis of price. And prices in the doctor market price are primarily not allocated research. That is not the way we allocate doctor time. And the same is true of hospitals. The hospitals are not competing with each other on the basis of price, and prices in the hospital marketplace are not allocating resources. The examples of hospital prices that Representative Lipinski gave us are examples of prices that are pure artifacts. They were chosen by hospitals in order to maximize reimbursement formulas. They are not equating supply and demand.

Now, although we like to think that our health care system is very different from the system in Canada, the fact of the matter is that we pay doctors here about the same way that doctors are paid in Canada. On average, every time patients spend $1 in this system, only .10 is paid out of pocket at a doctor's office. In Canada the physicians and services are free. In America they are almost free. In both countries we are not allocating the doctor's time on the basis of price. We are not rationing on the basis of money. We are rationing by the patient's time. We are rationing by waiting.

Now, does the health care marketplace have to work this way? The answer is no. And Dr. Ginsburg pointed to the example of cosmetic surgery and LASIK surgery. These are important markets. Third party payers have not been in these markets for years. For cosmetic surgeries probably two decades since third party payers paid. What we found in these markets is price is readily available. It is not just a price, it is a package price that covers doctor, nurse, and anesthetists, and facility. People know what they are going to pay. Now Dr. Ginsburg said we have some problems in this market. Well, we may have problems but they pale in comparison. They are miniscule in comparison to the problems that Dan Rather talked about on Sunday night on 60 Minutes that we are having with other kinds of surgery.

Now, we can find other examples in the medical marketplace where third party payers are not involved. Wherever the third party is not involved, we find prices performing the normal function that we expect prices to be found. Minute clinics in the Target stores in the upper Midwest have prices for all their procedures. People know what they are going to pay, there is very little waiting, and they work very well. Wal-Mart wants to take this system nationwide. Steve Kassis' organization also wants to take them nationwide. No third parties are involved. The TelaDoc service, you can actually talk to doctors on the telephone with this service. You know what you are going to pay, you are charged for the number of minutes you talk. Prices are very visible, they are very transparent, and it works very well. Luminous now allows patients to email their doctors and have email consultations. People know exactly what they are going to pay. They pay from their health savings accounts.

Going forward, we have remarkable new technologies that I think do not require any legislation. We simply need to let these technologies spread. For drugs, RX Examiner allows patients to see where the authentic and generic substitutes and over the counter substitutes for expensive brand name drugs. And DestinationRx.com allows patients to compare prices nationwide. And I would guess that the average patient can cut his drug prices in half simply by shopping nationwide for drugs. Some patients can cut their cost by 90 percent, enormous opportunity for reduction in cost.

In HealthMarket we have already heard has a brand new technology that is really exciting. Prices for 400,000 doctors and 20,000 procedures readily available with a computer program. Simbro is a company that has developed a product that allows a lot of quality comparisons among hospitals. eMedicalfiles allows another kind of transparency. It allows the doctors to see what other doctors have done and what is happening in other facilities for the patient, and does it all while protecting the privacy in accordance with the HIPAA regulations.

I would say that the most important factor that we can identify in all of this is empowering patients. That is why I think we need expanded medical savings accounts, and flexible medical savings accounts. Forget the high deductible, forget the co-payment, we just need the patients being in charge of the money. The supply side will respond.

Thank you, Mr. Chairman.

[The prepared statement of Dr. John Goodman follows:]

PREPARED STATEMENT OF DR. JOHN GOODMAN, PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS

Will consumers some day be able to shop for health care the way they shop for groceries? As farfetched as that idea may seem, some believe it will become a reality. But in order for patients to become savvy shoppers in the medical marketplace, they must be able to discover what things cost and to compare prices as well as value. Today, that is not easy to do.

A recent Harris Poll found that consumers can guess the price of a new Honda Accord within $300. But when asked to estimate the cost of a four-day stay in the hospital, those same consumers were off by $8,100! Further, 63 percent of those who had received medical care the last two years did not know the cost of the treatment until the bill arrived. Ten percent said they never learned the cost.[1]

This is not an academic issue. If you are like most other Americans, your employer has raised your health insurance deductible and copayment within the last few years. And, you may have a special account from which to pay bills directly. Increasingly, employees are being asked to make their own choices and manage their own health care dollars.

The medical marketplace is not prepared for these changes. Not only do patients typically not know the cost of the medical services they receive, the institutions of health care delivery often make price and quality information difficult, if not impossible, to obtain.

Why is information consumers have ready access to in other markets not generally available in health care? What institutional and technological changes are needed in order to make such information routinely available prior to health purchases? What is the appropriate role for public policy?

Source of the Problem

The principal reason why prices are not publicly quoted and commonly known in health care is that prices do not serve the function in health care that they do in other markets. Specifically, doctors and hospitals do not compete on the basis of price and prices do not ration scarce resources the way they do in other markets.

Although ours is a very different system from the health care system of Canada,[2] the way in which we pay providers in both countries is surprisingly similar. In general, fees are set by third-party institutions and those institutions pay all, or almost all, of those fees.

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[1] Kathy Gurchiek,"Consumers savvier about cost of a new care than a hospital stay," *Human Resource News*, August 2, 2005.

[2] John C. Goodman, Gerald L. Musgrave, & Devon M. Herrick. *Lives at Risk: Single-Payer National Health Insurance Around the World. (* Lanham, Maryland: Rowman and Littlefield Publishers, 2004.)

On the average, every time Americans spend a dollar on physicians' services, only 11 cents is paid out-of-pocket; the remainder is paid by a third party (an employer, insurance company or government).[3] From a purely economic perspective, then, our incentive is to consume these services until their value to us is only 11 cents on the dollar. Moreover, millions of Americans do not even pay the 11 cents. Medicaid enrollees, Medicare enrollees who have medigap insurance, and people who get free care from community health centers and hospital emergency rooms pay nothing at the point of service. Most members of HMOs and PPOs make only a modest copayment for primary care services. Clearly we are not rationing health care on the basis of price.

But if not price rationing, how do we ration physicians' services? We ration the same way other developed countries ration care. We force people to pay for care with their time. The services of physicians are a scarce resource and a valuable resource. So at a price of zero (or at a very low out-of-pocket price) the demand for these services far exceeds supply. Unable to bring supply and demand into balance with money prices, our system does that next best thing. We ration by waiting.

Some may object that the real demand for physicians' services is not determined by time or money but by the amount of sickness in society. Yet this view is surely wrong.[4] Consider that 12 billion times a year Americans purchase over-the-counter (OTC) drugs and suppose that on their way to these acts of self-medication all of the purchasers stopped to get professional advice. To meet that demand, we would need 25 times the number of primary care physicians we currently have![5]

Now suppose that instead of physically going to a doctor's office, purchasers of OTC drugs could get professional advice by means of telephone or email. The same problem would arise. The demand for advice would far exceed the ability of physicians to supply it.

In general, patients cannot have the best of both worlds. If they communicate with doctors the way they communicate with lawyers, they will have to be charged money prices for the use of the doctor's time (the way they pay legal fees). Health care cannot be both easily accessible and free. It must be one or the other. Waiting is not an accidental by product of modern health care delivery. It is an essential ingredient.

What difference does this make? A great deal of difference. In general, if doctors do not compete with each other on the basis of price, they do not compete at all.

One consequence of rationing by waiting is that the time of the primary care physician is usually fully booked, unless she is starting a new practice or working in a rural area. This means that almost all the physician's hours are spent on billable activities. Further, there is very little incentive to compete for patients the way other professionals compete for clients. The reason: neither the loss of existing patients nor a gain of new patients would affect the doctor's income very much. Loss of existing patients for example, would tend to reduce the average waiting time for the remaining patients. But with shorter waiting times, those patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency we use to pay for care, the physician doesn't benefit (very much) from patient

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[3] K. Levit, C. Smith, C. Cowan, H. Lazenby, A. Sensenig, & A. Catlin. 2003, "Trends in U.S. Health Care Spending, 2001" *Health Affairs*, *22*(1), pp. 154-164.

[5] Simon Rottenberg. "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, 1990, *13*(2), 27-28.

pleasing improvements and is not harmed (very much) by an increase in patient irritations.

What about the hospital sector? As is the case for physician services, fees for hospital services are set and paid by third-party payers. And, as is the case for physician services, the scarce resource again is the doctor's time. Here, however, it is not patients who are waiting on doctors; it is hospital beds (and other facilities) that wait on doctors. In many ways, the two sectors are mirror images of each other. In neither sector do prices clear markets. And in neither sector is competition among providers based on price.

Can Health Markets be Different?

There is nothing normal or natural about rationing by waiting. The exterior offices of lawyers, accountants, architects and other professionals are called "reception areas," not "waiting rooms," and very little waiting actually goes on. The reason: waiting is a wasteful way to allocate resources. In markets for other goods and services, the consumer's cost is typically the producer/seller's income. But when people pay for goods with their time, their waiting cost is not someone else's income. It is a net social loss.

Rationing by waiting is not only socially wasteful, it is a poor way of delivering health care. Under such a system, there is no way to insure that those who need care the most get it first, or even get care at all.[6] Human resource experts estimate that one-quarter of physicians visits are for conditions that patients could easily treat themselves.[7] Balanced against these "unnecessary" visits are all of the potential visitors who choose not to seek care. Undoubtedly, many of those are "necessary" but unrealized visits; and, hence, the patients go without professional treatment.

To find radically different physician behavior, one must look at markets where third-party payers are not involved at all, such as the markets for cosmetic and lasik surgery. Unlike other forms of surgery, the typical cosmetic surgery patient can (a) find a package price in advance covering all services and facilities, (b) compare prices prior to the surgery and (c) pay a price that is lower in real terms than the price charged a decade ago for comparable procedures — despite the considerable technological innovations in the interim.[8]

Ironically, many physicians who perform cosmetic surgery also perform other types of surgery. The difference in behavior is apparently related to how they are paid. A cosmetic surgery transaction has all the characteristics of a normal market transaction in which the seller has a financial interest in how all aspects of the transition affect the buyer. In more typical doctor-patient interactions, doctors are not paid to be concerned about all aspects of care and therefore typically ignore the effects on the patient of the cost of time, the cost of drugs, and other ancillary costs. Note, this holds for HMO doctors as well as fee-for-service doctors and what is true for U.S. doctors in general is also true of doctors who practice in the government-run health systems of other developed countries.

Whenever there is waste and inefficiency in a market, there is an opportunity for entrepreneurs to make profits by eliminating that waste and inefficiency. The health care market is no exception. What makes entrepreneurship difficult in health care is that in

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[6] Goodman, et al. *Lives at Risk*.

[7] D.R. Powell, "Implementing a Medical Self-Care Program," *Employee Benefits Journal*, International Foundation of Employee Benefit Programs. September 2003.

[8] Devon Herrick. "Why Are Health Costs Rising?" *National Center for Policy Analysis*, Brief Analysis No. 437, 2003.

order to eliminate waste and inefficiency, the entrepreneurs must step outside of the normal payment mechanisms. This means that patients who take advantage of these services often must pay out-of-pocket for what theoretically should be covered by their insurer.

The entrepreneurial activities we have identified tend to have two characteristics: (a) they allow patients to economize on time and (b) they step outside the normal reimbursement channels, usually asking for payment at the time of service. Here are some examples:

- *Minute clinics.* These are walk-in clinics located in selected Target and Club Food stores and some CVS Pharmacies, and Wal-Mart has signaled its interest in providing a similar service through its stores nationwide. They are staffed by nurse practitioners. No appointments necessary and most office visits take only 15 minutes. Treatments range from $25 to $105. In contrast to standard physician practice, medical records are stored electronically and prescriptions are also ordered that way.
- *TelaDoc.* This service offers medical consultations by telephone. A doctor usually returns patient's calls within 30 to 40 minutes. If the call is returned later than 3 hours the consultation is free. Access is available around the clock. Registration for the service costs $18. Phone consultations are $35 each, with a monthly membership fee ranging from $4.25 to $7.
- *Doctokr.* This is the Virginia medical practice of Dr. Alan Dappen. Although he offers in-office appointments, he encourages most patients to have either an e-mail consultation or a phone consultation. Dappen charges based on the amount of time required. A simple consultation generally costs less than $20.
- *CashDoctor.com.* This is a loosely-structured network for doctors across the country that are "cash friendly." Practices styles and fee schedules are available online.

Is Needed Technology Available?

It is possible to have a health care system in which third-party payers neither set the fees nor pay the fees of providers. For example if health insurance worked like casualty insurance (the type of insurance people purchase for their homes and automobiles), insurance reimbursements would cover the expected cost of care for most providers; but patients would be free to negotiate with individual providers and pay more (for better service) if they found extra value warranted the extra charge.

Even in this imaginary market, however, there has to be a way for patients to gain access to price and quality information. So how exactly would that work? Some assume that we need a new government program to kick-start needed technological changes. Yet while pundits talk and politicians threaten to legislate, the private sector already has developed many of the tools to solve these problems.

- In the market for drugs, the web site Rxaminer.com allows patients to discover therapeutic and generic substitutes for brand name drugs as well as over-the-counter alternatives; the site DestinationRx.com allows patients to compare prices nationwide.
- A model developed by Health Market allows its insureds to compare the price they will pay for 20,000 procedures performed by virtually every doctor in the country.
- A product developed by Subimo allows patients to compare quality and price data for most hospitals in the country.

- A product developed by eMedical/files creates needed transparency for doctors – it allows medical records to travel electronically as patients go from doctor to doctor and hospital.

What Public Policy Changes are Needed?

If we do not need government to fund or regulate new technologies, what changes are needed? New government policies can help in two ways. First, in markets where government is the primary third-party payer (e.g., Medicare or Medicaid), policymakers can use existing technology to let its own insureds have access to price and quality information. (Some modest steps in the right direction are already underway.)

Second, we need to change the tax law to make it easier for people to self-insure for medical expenses instead of over-relying on third-party insurance. In order to have a workable, well-functioning medical marketplace, we need to fundamentally change the way we pay for health care, including the way we pay doctors. A step in the right direction is the creation of Health Savings Accounts (HSAs). Instead of an employer or insurer paying all the medical bills, about 3.2 million people are managing some of their own health care dollars through these accounts and another 3 million have Health Reimbursement Arrangements.[9]

Despite their many advantages, HSAs can be made even better. Under the current system, HSA plans with deductibles and copayments graph onto the current payment system and reinforce it rather than challenge it. Under the current HSA rules, if a patient pays for care with dollars, those dollars count toward a deductible and move the patient closer to the point when a third-party will pay all remaining financial costs. But if a patient pays for care with time, this does not count toward the deductible. Further under most HSA plans, time-saving innovations are typically not covered expenses. In these ways, most HSA plans are tacked on to the existing payment system, rather than an alternative to it.

The current HSA law's primary problem is that decisions the market should make have been made by the tax-writing committees of the U.S. Congress instead. What is the appropriate deductible for which service? How much should be deposited in the HSAs of different employees? How can we use these accounts to meet the needs of the chronically ill? In finding answers, markets are smarter than any one of us because they benefit from the best thinking of everyone. Further, as medical science and technology advance, the best answer today may not be the best answer tomorrow.

MR. DEAL. Thank you.

Dr. Anderson?

DR. ANDERSON. I do not know if I am going to make it.

MR. DEAL. Switch chairs?

DR. ANDERSON. No, I think I will be fine, I am a loud person.

Thank you, Mr. Chairman for the opportunity to testify this morning.

My overall message is that simply publishing prices will not allow consumer to comparison shop and will not bring prices down. Additional information will be necessary for comparison shopping to occur. Let us assume you went to the hospital and the hospital presented you with their price list. The price list is called a charge master file and

[9] Source: HealthMarket Survey, U.S. Census Bureau and Americas Health Insurance Plans (AHIP), 2006.

it lists the prices for approximately 25,000 different items. First, you probably would not understand most of the items on the charge master file. As a result of the testimony I gave two years ago at an Energy and Commerce Committee hearing, I have been involved in numerous court suits involving the rates that hospitals charge the uninsured. I also was on 60 Minutes last week talking about this issue.

Because of many of these court suits, I have been reading far too many charge master files. One of the items on the charge master file for example is the head bugger upper body cover. The charge for one hospital is $77.50 for that. Another item on the charge master file was the lactated wingers and the charge at that hospital is $189. Charge master files have 25,000 different items like this. The normal person and probably most doctors cannot understand what is on the charge master file. In order for price lists to be useful, the price lists need to be understandable.

Second, a patient needs to know which of these 25,000 items on the charge master file he or she will need. Most patients entering the hospital have no idea what services they would need. Should they compare prices for the head bugger upper body cover? Should they compare it for the lactated ringers? The typical patient, in-patient, will probably need only 50 different items. The problem is you do not know which of these 25,000 items you are going to need, and it is unlikely the hospital or the doctor can tell you in advance which of these 50 items you are likely to need. Transparency, price transparency works only if you know what you are going to buy.

Third, the patient is unlikely to be making the final decisions. The team of doctors caring for you is the one who makes the final decisions. When you go to the emergency room because you broke your wrist, you do not make the final decisions. Same story when you go to the hospital for cancer treatments or to treat your diabetes. The decisions are generally left to the doctor because most of us do not know what a head bugger upper body cover or a lactated ringer even does.

Fourth, the prices that you will be quoted on the charge master file are not the prices that most people pay. In my testimony, I include a tape of the charge to cost ratios for hospitals in each State. In 2003, New Jersey had the highest charge to cost ratio at 3.75. What this means is that New Jersey hospitals charge $3.75 for an item that costs them $1. Does this mean that hospitals in New Jersey are earning enormous profits? No. Available data suggested New Jersey hospitals are earning only small profits. The reason is clear. Although they charge $3.75 for an item that costs them a dollar, they do not receive $3.75 from these patients. Health insurers, health plans, Medicare, and Medicaid do not pay full charges. They negotiate rates, we negotiate rates which are

much closer to cost than to full charges. The only patients asked to pay these full charges are the uninsured, some people with high deductible health savings accounts, and the international visitors. It does not make sense to post prices that only a few patients actually pay. For the prices to be useful, they need to reflect what most insurers are actually paying and not the hospitals price wish list.

Fifth, the prices can change daily. A person could do comparison shopping and find the best price. Then when they actually enter the hospital, they would find that all the prices have changed. In fact, the prices could change while the person was in the hospital. It would be necessary to force the hospital to maintain its price to allow comparison shopping.

Sixth, if you require hospitals to disclose prices for just a limited set of procedures, it would lower the prices for just those limited set of procedures. Would you go into a Wal-Mart if they would tell you the prices for only 50 items but wanted you to buy everything?

My testimony so far has only focused on hospitals. Inadequacy of simply posting prices also applies to physicians and drug plans. For example, the Medicare prescription drug plans can change the prices of prescription drugs any time they choose. They can also change the co-insure amounts any time they choose. As a result, a Medicare beneficiary who initially found the least expensive plan may quickly find that these prices have all changed.

So what can be done to improve price transparency? My proposal is to require all providers to quote their prices in terms of Medicare rates. The hospital or physician could say I charge X percent of the Medicare rate. One hospital might charge 120 percent of the Medicare rate and other hospital would charge 125 percent of the Medicare rate. For certain items, the hospital or physician could deviate from the Medicare rate. The advantage to this is it would allow each patient to compare one number, one price. The Medicare rates are publicly available information and nearly all doctors and hospitals are familiar with Medicare prices. Currently there are 25,000 items on the hospital charge master file and over 10,000 items CPT codes that physicians use. There is no way for a patient to compare this many prices especially when he or she does not even know what services she is going to use.

I appreciate the opportunity to testify this morning.

[The prepared statement of Dr. Gerard F. Anderson follows:]

PREPARED STATEMENT OF DR. GERALD F. ANDERSON, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, HEALTH POLICY AND MANAGEMENT

Mr. Chairman, members of the Committee, thank you for this opportunity to testify this morning. My name is Gerard Anderson and I am a professor in the Bloomberg

School of Public Health and a professor in the School of Medicine at Johns Hopkins University. I am also the Director of the Johns Hopkins Center for Hospital Finance and Management.

I believe health care prices should be more transparent. Currently, it is very difficult for consumers to be aware of the prices that they will pay for hospital, physician, and other medical services as well as the prices they will pay for products such as drugs. However, ***simply publishing the price will not allow patients to compare prices and will not bring prices down***. ***Two additional steps are necessary***. ***First, patients need to know what services they will use.*** Most patients do not understand what goods and services they may need and so they cannot do comparative shopping. ***Second, prices must reflect market forces***. List prices are established by the hospitals and physicians without any market constraints. Too often list prices have no relationship to the prices that are actually being paid by insurers. The prices should reflect the market place and should not be dictated by only the hospitals and physicians. ***One way to allow prices to be more transparent is to base all rates on a single price standard.*** The Medicare payment rate is one logical suggestion and one that is commonly used in negotiations between insurers and providers. ***Providers could simply say that they charge X% of the Medicare rate.***

Why Does The United States Spend So Much on Medical Care? – Its Prices Stupid

Making patients aware of the prices they are paying for medical services is especially important when you compare the prices that Americans pay for medical services to the prices people pay in other countries for similar services. Every year I write an article in the journal Health Affairs which compares the level of spending on health care services in the United States to the level of spending in other countries. I have attached a copy of the most recent article in this series.

What the article shows every year is that the ***United States spends nearly twice as much for medical care as many other industrialized countries***. In 2003 (the most recent year comparative data is available) the United States spent $ 5635 per person compared to $ 3003 in Canada, $2996 in Germany, $2231 in the United Kingdom and $ 2139 in Japan.

These higher levels of expenditures can make it difficult for American industry to compete in the international market place. For example, the financial problem the American auto industry is having is partially related to the high costs of medical care. The price of a car sold by General Motors includes over $1500 in health care costs. In other countries, cars incorporate much lower health care costs.

Each year we use the article in Health Affairs to investigate why health care in the United States is so much more expensive compared to the other countries. We have investigated a number of hypotheses including: malpractice costs, defensive medicine, aging of the population, the lack of waiting lists in the United States, the obesity levels in the United States, and the high level of technology that is available in the United States. We have investigated each of these factors in one or more of the articles.

What we have found is that each factor is partially responsible for the higher costs in the United States. However, none of them really explains why the United States spends nearly twice as much as other industrialized countries.

As we continue to examine the data we have reached the following conclusion - "***Its Prices Stupid.***" This was the title of our article in Health Affairs in 2003 and it remains our primary conclusion of why health care in the United States is so expensive today.

Comparing Drug , Hospital and Physician Prices in the United States to the Prices Other Countries

In 2004, we published an article in Health Affairs entitled Doughnut Holes and Price Controls which compared the drug prices for the 25 most commonly prescribed drugs (both brand name and generic) in the United States to the drug prices for the same 25

drugs in Canada, France and, the United Kingdom. What the article shows is that ***the United States patient is paying approximately double the prices for drugs as patients in Canada, France and the United Kingdom are paying.*** This explains the desire for reimportation among United States consumers.

We have also compared the expenditures for hospital and physician services. The United States spends twice as much per capita for hospital and physician services as other industrialized countries. When we examined the reason we first discovered that quantity was not the reason – Americans are receiving fewer hospital days per capita and fewer physician visits per capita than people in most other industrialized countries. In fact, managed care and other initiatives have eliminated many unnecessary hospitalizations and shortened the average length of a hospital stay.

A second explanation we examined was technology and we found that access to expensive technology was not a major reason for the higher per capita hospital spending. The United States, for example, has approximately the same number of CT scanners and MRI machines as the average industrialized country. The Japanese have access to the most technology. For example, Japan has 4 times more MRIs per capita and 7 times more CT scanners per capita than the United States. In spite of using all this technology, health expenditures per capita in Japan are only 38 percent of the United States.

Per capita spending for American hospital services is more much more expensive than other industrialized countries because of the price of a hospital day. **The price of a day in an American hospital is nearly two and a half times the price of a hospital stay in other industrialized countries.**

A similar argument can be made for physician services. Americans do not receive more physician services than people in other industrialized countries. ***Yet the price of a physician visit in the United States is over twice the price in other countries.***

Because of the work we have done comparing the prices in the United States to the prices in other countries I am in total support of the efforts to control prices in the United States. ***The reason why the United States health care system is much more expensive can be summarized in three words – "Its Prices Stupid."***

Policy Initiatives To Control Prices in the United States

Public payors such as Medicare and Medicaid have undertaken a number of initiatives to control prices. The first major initiative was the Prospective Payment System to control hospital rates in the Medicare program. It was soon followed by the Resource Based Relative Value System that is used to pay physicians in Medicare. Other prospective payment systems have followed for other types of providers. Medicaid programs have followed a similar approach to Medicare.

Over the past 20 years little public policy attention has focused on controlling prices in the private sector. The last public policy attempt to control prices in the private sector was President Carter's Hospital Cost Containment initiative. This was an attempt to control the rate of increase in hospital rates for all insurers and for self pay patients.

It is always surprising to me that ***prices are substantially higher in the private sector than they are in the public sector.*** MedPAC numbers continually show that the private sector pays 10 – 20 percent (and in some years more) than the public sector. I have often wondered why the private sector cannot get better rates. Some have argued that the public sector shifts costs to the private sector. The real policy question is why the private sector allows the "cost shift" to occur. Why can not the private sector use competitive forces to get lower rates than the public sector?

Because the private sector is paying higher rates than the public sector, the public sector has difficulty keeping prices low. If the public sector was paying substantially lower rates then the hospitals and physicians could restrict access to public beneficiaries. The differential between the public and private rates cannot become too great. The public

and private sectors need to be able to work together to keep prices low. In the United States this means ***the private sector becoming a strong force in controlling prices.***

Does the United States Get Value For the Higher Prices?

It is difficult to compare outcomes across countries. Without an ability to compare outcomes it is impossible to calculate value. There have been a number of initiatives to compare outcomes.

For years we have known that the life expectancy is lower in the United States than in many other industrialized countries and that the infant mortality rates are generally higher. This would suggest that we are not getting value for the much higher spending in the United States. Critics of these comparisons have correctly pointed out that life expectancy and infant mortality rates are determined by many factors and that health care may play only a minor role.

To examine if the health care in the United States is better than the health care in other countries we conducted a study comparing the clinical outcomes in the United States to the clinical outcomes in England, Australia, New Zealand, and Canada. We selected 21 indicators to compare. For example, two of the indicators were 5 year survival rates following a diagnosis of breast cancer and mortality from asthma in people are 5 -39. The 21 indicators covered a number of illness categories but were not designed to be a comprehensive list.

What we found was that the United States was the best on a few indicators, the worst on a few indicators, and in the middle on most indicators. Not a good showing for a country that spends more than twice as much per capita as these other countries. ***Internationally it is clear that higher prices in the United States do not necessarily result in better outcomes.***

We have also looked at how these other countries have been able to control prices for hospitals, physicians, drugs and other goods and services. The answer in some other countries is that the prices are set by the government. In other countries all the insurers get together and negotiate as a group with the providers**.** Imagine all the insurers on one side of the table and all the providers on the other side of the table and the end result of the negotiation is a set of prices that all insurers will pay.

An examination of the experiences of these other countries suggests that either ***regulation or collective negotiation could work if the objective was to control health care prices***. There are, however, a number of obstacles to overcome. United States policy makers have not believed that regulation is an effective way to control prices and having all insurers negotiate together would violate antitrust policy.

Pricing Transparency – What Else Is Needed

For the reasons discussed above, I am in favor of a renewed policy emphasis on lowering health care prices. The United States is now considering a different approach – to make prices more transparent. This approach has some merit although ***simply posting prices will not achieve the objective of allowing consumers to engage in comparison shopping and will not bring down prices without additional steps being taken***. The remainder of my testimony suggests what else needs to be done and finally makes suggestions regarding what actions the Congress should take in addition to requiring prices to be posted

First, it is critical for patients to know the services they are going to use. ***Comparison shopping is not possible if the patient does not know what goods and services he/she is are going to buy. Second, the prices need to be reasonable. By reasonable I mean the prices must reflect what is being paid in the market place.*** The list prices that are established by hospitals and doctors generally do not reflect what insurers are actually paying.

Comparison Shopping

Imagine going into a grocery store or a department store and not understanding: (1) what most of the products you are purchasing actually do, (2) what is actually on the bill, and (3) having no idea what you are going to buy when you enter the store. In this case you would not be a good comparative shopper even if you knew the prices. ***You need to understand what you are buying before you make the purchase.***

In health care there is often an additional factor. Imagine that you are not even the person picking out the goods in the grocery store or the department store. ***Imagine that someone else is making the decisions about what to buy for you***. Health professionals, most commonly doctors, make most of the decisions when you go to the doctor's office or the hospital. For many clinical conditions this will always be the case.

The following sections explain why simply requiring hospitals, physicians, and drug plans to post prices is insufficient. Without these additional steps, the market place will not work and comparison shopping will not be possible.

Hospitals

The hospital charge master file lists the prices for each service the hospital provides. The hospital charge master file contains 10,000 items in a small hospital and 50,000 items in a large hospital. ***Simply posting the prices on the charge master file will provide the patient little information if the patient wants to do comparison shopping for hospital services***.

1. The typical hospital bill contains 10 to 500 items. These could be $1000 for an hour of operating room time or $5 for a Tylenol. The patient will never use most of the items on the charge master file. Without knowing what services he/she will use it is impossible for the patient to do comparison shopping.
2. Unfortunately, in most cases ***hospitals and/or the doctor cannot tell the patient in advance which services they will need.*** The hospital or the physician may estimate that the procedure may require an hour of operating room time but the operation may require only 30 minutes or may require two hours. The hospital or the physician cannot know if the patient will want or need a Tylenol. Without knowing precisely what services are going to be used it is impossible to really do comparison shopping. Should the patient compare prices for 30 minutes, 60 minutes or 120 minutes of operating room time? Should the patient compare prices for Tylenol or ibuprofen?
3. Comparing the 10,000 to 50,000 items on the charge master file is foolish when the patient will probably use less than 100. The problem is that the patient does not know exactly which 100.
4. Many of the items on the charge master file and ultimately on the hospital bill are written in code so that only the hospital administrators and a few other experts in the field can understand. ***The charge master file will need to be translated if the consumer is going to understand what he/she is buying.***
5. I examined a hospital bill for a person who was charged over $30000 for an outpatient procedure. A $30000 charge for a procedure that did not even require an overnight stay.
6. The bill contained numerous charges. Many of the services on the bill were written in a strange language. I wonder how many people in this hearing room know what a "Bairhugger upper body cov'" is or why the charge is $77.55. The same hospital bill contained the following items and associated charges:
    a. Furosemide/20MG/2ML/V – $4.54
    b. Toradol 30MG/ML 1ML S - $ 22.02
    c. Versed 1 MG/ML 2CC VIA - $11.37
    d. Lactated Ringers 2B2324 - $189.00
    e. Valve IV - $7.15

f. Pack Custom Cysto - $58.00
g. Set Tur - $35.35
h. **Zofran 1 Mg dose – 155.18

If the consumer is going to effectively comparison shop, then these items will need to be described in English.

7. Hospitals are currently allowed to change their prices at any time. A patient could comparative shop for hospital services on Monday and enter the hospital on Tuesday and find that the prices have all been changed. In fact, the patient could enter the hospital on Tuesday and remain in the hospital until Friday and see the prices changed every day they were in the hospital. This same issue applies to the Medicare Prescription Drug benefit. The drug plans are able to change their prices at any time. ***If patients are going to engage in comparative shopping the prices have to be fixed so that the patients can compare prices.***

Physicians

1. In most cases it is the physician who is making the decision about what type of care the patient will receive. The physician is unable to provide any guarantees in most cases concerning what services he/she will ultimately provide. As a result, comparative shopping will be impossible since you do not know the prices of what services to compare.
2. ***Comparison shopping for certain physician services is possible***. Probably the best example is LASIK surgery. It is a relatively standard procedure and therefore it is possible for the physician and the patient to compare services and compare prices. In this case a price list is probably sufficient. LASIK, however, is more the exception than the rule.
3. The more common encounter between a physician and a patient is when the patient does not exactly know what is wrong and the physician has to order a series of tests to discover what is wrong and then to decide on the appropriate treatment. This cannot be predicted at the beginning. Then once the treatment starts it is often unclear what will be needed and how long it will take.
4. For example, each woman with breast cancer will probably respond differently to treatment. As a result, the oncologist cannot specify in advance what services will be provided or what will be charged. If a woman was trying to comparative shop for an oncologist she would need to know what services will be provided and not just the prices that will be charged for services that she may or may not need. The same principle applies to people with chronic conditions such as diabetes, congestive heart failure, or asthma. No physician can tell the patient in advance what services he/she will require in the next year and therefore true comparison shopping will be impossible.
5. In the Medicare program ***two thirds of Medicare spending is by the 23% of beneficiaries with 5 or more chronic conditions***. These beneficiaries see an average of 13 different physicians during the year. Their condition is always changing. ***It will be impossible for these beneficiaries to predict what services they will need in the coming year and therefore comparison shopping for physician services is impossible.***

Pharmaceuticals

1. The Medicare Modernization Act allows Medicare beneficiaries to compare drug prices in different health plans. Many consumers have found this comparison shopping very difficult.
2. The drug plans participating in Medicare Part D do not have to disclose the price that they are paying for the drugs. All that is provided to the Medicare

beneficiary is the retail price. Drug plans are likely to obtain discounts from the pharmaceutical companies.

3. Medicare beneficiaries are locked in to a specific drug plan which they choose based on the prices of the drugs and the cost sharing arrangements. However, the drug plans are free to change prices and change cost sharing arrangements during the year. ***A drug plan that was the least expensive for a beneficiary with one set of prices could become a very expensive plan if the drug plan changed the prices during the year or changed the cost sharing arrangements.***
4. Next year another problem is likely to arise – ***Medicare beneficiaries developing new diseases which require new drugs that they did not anticipate.***
5. A major problem for Medicare beneficiaries doing comparative shopping is that they are locked in to a particular plan for a year. Many have found the least expensive plan assuming their use of drugs does not change during the year. However, for millions of Medicare beneficiaries the drug regimen is likely to change and at that time they may not have the least expensive plan.
6. Unfortunately, Medicare beneficiaries get sicker as they age. Some years they develop a new chronic condition and that chronic condition may require them to take a new drug or multiple new drugs. The typical Medicare beneficiary acquires an additional chronic condition every two or three years. As noted earlier in this testimony, 23% of Medicare beneficiaries have 5 or more chronic conditions. These beneficiaries fill an average of 50 prescriptions during the calendar year. Many of them change prescriptions during the year.
7. Without knowing what drugs you are going to use in the year it is difficult to do comparative shopping.

In summary, price comparisons have little value unless the person knows exactly what goods and services they are buying. In health care it is difficult to predict in advance what goods and services will be needed and doing comparison shopping while a procedure is being done is not generally feasible.

Reasonable Prices

It is not sufficient simply to post prices. The prices must be reasonable. ***By reasonable I mean that the prices must reflect the market place***. The list prices that are in the hospital charge master file do not reflect market forces for reasons that will be described below. The same applies to most physician charges.

Let's assume that a hospital had prices of $1,000,000 per day. Would that be a reasonable price? I suspect most reasonable people would say no. What if a doctor had prices of $1,000,000 for an office visit – would that be a reasonable price? Again I believe most reasonable people would argue that $1,000,000 for an office visit is an unreasonable price.

Under the current system hospitals and physicians have the ability to post any price they choose. There is not a requirement that anyone ever pays that posted price and in fact the posted price is seldom paid.

The question then becomes how does Congress determine what is a reasonable price? It makes no sense to require hospitals and physicians and others to post unreasonable prices. Two possible standards to determine if the prices are reasonable are (1) costs and (2) the market place.

Costs are relatively easy to calculate for hospitals. Groups such as MedPAC routinely use costs to compare to what Medicare is paying. The Medicare Cost Report calculates Medicare allowable costs for nearly every hospital in the United States. Costs are more difficult to calculate for physicians, health plans, etc.

One reason for not using costs is that they do not encourage efficiency. The prices could be high because the hospital is very inefficient. A second reason for not using costs

to determine if the price is reasonable is that costs may not reflect market forces. A hospital with very high costs may be unable to lower its prices sufficiently to enter into an agreement with a health plan or an insurer.

An alternative is to use the ***prices that are actually being paid in the market place***. The prices reflect the discounts that hospitals, physicians and other groups negotiate with insurers.

The charge master file submitted by the hospital does not reflect market prices. In most cases neither do the charges established by physicians. Few patients actually pay these charges. ***Insurers obtain large discounts off these list prices – often as high as 75 percent***. I have actually seen contracts where the discount from list price was over 900 percent and in this case the hospital was still earning a profit from the insurer because the negotiated rate was above the hospital's actual costs. For a price list to be reasonable it needs to reflect what is actually being charged in the market place.

Because the issue is easier to understand in the hospital context, I will focus on the unreasonableness of hospital charges as shown in the charge master file.

How Charges Are Set By Hospitals

Hospital charges are determined by a charge master file and the hospital or hospital system determines the charges in the charge master file. ***The hospital or hospital system has complete discretion to set each and every charge on the charge master file.***

The hospitals often do not know how they set each charge on the charge master file. There is not a formula that hospitals use to set charges.

According a December 2005 MedPAC report entitled "A Study of Hospital Charge Setting Practices" "The hospital charge description master (CDM), or "charge master" is extensive, usually containing between 12,000 and 45,000 individual charge items and procedures across hospital department providing patient services. Every chargeable item in the hospital must be part of the charge master in order to bill the patient, payer, or health care provider."

The MedPAC report was based on interviews with 57 participating hospitals and/or systems involving 238 hospitals. Some of the quotes in the Report from the interviews the team conducted with hospital executives involved in setting hospital charges demonstrate that the ***charges are not set by market forces or using a systematic methodology.***

> "With over 45,000 items in the charge master, the vast majority have no relation to anything, and certainly not to cost."
>
> "There is no rationality to the charge master and costs still do not have much relevance."
>
> "Charges have less and less meaning each year…"

There have been numerous academic articles written describing how hospitals determine their charges. However, perhaps the most illuminating presentation was a newspaper article that was published in the Wall Street Journal on December 27, 2004 and written by Lucette Lagnado. The article takes advantage of the data on hospital charges that California hospitals are required to report. The article also contained a quote from William McGowan, chief financial officer at the University of California, Davis Health System and a 30 year veteran of hospital pricing policy implementation. In the article Mr. McGowen explained the rationale of hospitals charges "There is no method to the madness. As we went through the years, we had these ***cockamamie formulas***." His conclusion is not much different than what the hospital executives said to MedPAC in the December 2005 report.

The same Wall Street Journal article includes a chart that shows the variation in charges in seven California hospitals for services such as chest x-rays, complete blood count, CT Scan, Tylenol, etc. The chart below shows the variation in charges at the seven California hospitals for just Tylenol and a chest x-ray. The range for one tablet of

Tylenol was free to 7.06. The range for a routine chest x-ray was from $120 to $1519.00. These are substantial charge variations.

	Charge for Tylenol	Charge For x-ray
Scripps Memorial La Jolla	$7.06	$129.90
Sutter General – Sacramento	No Charge	790.00
UC Davis – Sacramento	1.00	451.50
San Francisco General	5.50	120.00
Doctors – Modesto	No Charge	1519.00
Cedars Sinai – LA	0.12	412.90
West Hills – West Hills	3.20	396.77

As noted earlier it would therefore be unreasonable to expect a person to do comparison shopping on all items in the charge master file, the vast majority of which he/she would never use. If you only had the information on this chart which hospital would you choose? The two hospitals that do not charge for Tylenol have the highest charges for an X-ray. Unless the patient knew if he/she would need an X-ray or would need Tylenol the price information is useless.

There are a few items on the charge master file where a consumer would know the products and could compare prices. These are items the person might purchase outside of the hospital. I reviewed the charge master file at one hospital and this is what I found.

In 2002, the charge for one tablet of ibuprofen was over $5.00. The charge for one chewable tablet of a multivitamin was also over $5.00. A 12 packet of Rolaids was over $10.00. If the person needed a 15 minute massage the charge was over $50.00 or over $200 per hour. In 2002, the person was being charged over $600 per day for a semiprivate room. Many of these charges increased in 2003, 2004, and 2005.

Why Hospital Charges Are Set So High

When a person goes to the drug store to purchase ibuprofen, multivitamins, or Rolaids the prices are clearly labeled. The prices in other drug stores are clearly labeled. A drug store that charges high prices will likely lose business. The market place operates.

In contrast, the amount that any hospital proposes to charge for ibuprofen, multivitamins or Rolaids or any of the other 25000+ items on the charge master file is not set by market forces. As a result, they are much higher than they would be if market forces prevailed. The following section explains why it is inappropriate for consumers to pay what is on the charge master file.

Before 1929, patients did not have health insurance and patients paid hospitals directly for each service. Patients paid charges. To some extent, market forces influenced the amount a hospital could charge. One hospital might charge $4.00 for a day in the hospital while another hospital charged $5.00. It was relatively simple for patients to compare hospital charges when all that the patient was comparing was one number – the price for a day in the hospital.

As the depression worsened in the 1930s, the ability of people to pay their hospital bills worsened. Blue Cross and other insurance programs developed in response to the inability of people to pay their hospital bills.

During this period, hospitals' charges were based on the cost of providing care, plus a markup typically of less than 10%. Because health insurers paid the charges, there was little or no gap between the amount billed and the amount collected by hospitals. Market forces were operating to some extent to hold-down charges.

By 1960 most hospitals had moved away from a per day charge and were using a charge master file to bill patients. In 1960, however, the charges set by hospitals were

still based on the cost of providing care plus a small allowance for profit. Most insurers continued to pay charges. The charge master listed all the services the hospital provided for the patient: ibuprofen, multivitamins, Rolaids, etc.

In 1960, the typical charge master file established by hospitals had 5000 separate items. This was a major expansion from 1930 when there was typically only a room and board charge. It was becoming difficult for market forces to operate by 1960 because an individual patient did not know which of the 5000 different items he/she would need. Comparison shopping was becoming more difficult.

The hospital bill was calculated by multiplying the amount on this charge master file by the number of units received. For example, if the hospital charged $1000 per day in the hospital for room and board and the person remained in the hospital for 4 days, the room and board charge would be $4000. Two hours in the operating room might cost $500. Other services the patient received would be added to this bill to calculate a total charge.

Competition for patients kept hospital charges close to the level of hospital costs. Nearly all hospital bills were paid on a charge basis. Market forces continued to operate to some extent through the early 1960s.

Fewer and Fewer Insurers Pay Full Charges After 1960

Between 1960 and 2003 fewer and fewer insurers paid hospitals on the basis of charges. First the public sector and then the private sector stopped paying full charges. When public and private insurers stopped paying hospitals on the basis of charges, market forces no longer served to hold down hospital charges. By 2003, market forces and regulations were operating to hold down hospital prices for many public and private insurers such as Medicare, Medicaid, United Healthcare, Anthem, and Premier.

At the same time, hospital charges were being increased to very high rates. This became know as "cost shifting." Cost shifting meant that patients being asked to pay full charges were paying higher and higher charges while the rate increases for insurers like Medicare, Medicaid, United Healthcare, Anthem, and Premier were much lower.

When the Medicare program was established in 1965, Congress decided that the Medicare program would pay hospital costs and not hospital charges. Congress recognized that charges were greater than costs and that the Medicare program would be able to exert little control over hospital charges. This was the first real break from paying hospital charges.

A very detailed hospital accounting form called the Medicare Cost Report was created to determine Medicare's allowable costs. In order to allocate costs between the Medicare program and other insurers, the Medicare program required hospitals to collect uniform charge information. For example, if 40% of the charges were attributed to the Medicare program, then the cost accounting system would allocate 40% of the costs to the Medicare program.

In order to prevent fraud and abuse, the Medicare program required hospitals to establish a uniform set of charges that would apply to all insurers. Otherwise, the hospital could allocate charges in such a way that would result in more costs to the Medicare program.

Hospitals continued to have complete discretion on how they established their charges. The Medicare program did not interfere with how hospitals set charges for specific services. The Medicare cost report simply required the hospitals to report their charges.

Two major changes occurred in the 1980s that severed any impact that market forces would have on hospital charges. One occurred in the public sector and the other occurred in the private sector.

First, Medicare created the Prospective Payment System for inpatient hospital services in 1983. In 1990, the Medicare program moved away from paying costs for

outpatient services and instituted the Ambulatory Payment Classification System that sets rates for outpatient services. Most Medicaid programs adopted their own Prospective Payment Systems.

Second, most private insurers began negotiating discounts or using some other mechanism other than paying charges to pay hospitals. Managed care plans began to negotiate with hospitals in the early 1980s. They wanted discounts in return for placing the hospital in their network. They successfully negotiated sizeable discounts with hospitals. As indemnity insurers began to compete with managed care plans in the mid 1980s, they also began to move away from paying full charges and started negotiating their own deals. Nearly all indemnity insurers and managed care plans stopped using full charges as the basis of payment by 1990.

Insurers such as Aetna, Cigna, Medical Mutual, and United Healthcare get substantial discounts. In many hospitals these insurers are paying only one third of the billed charges.

Comparing Hospital Charges

Because of these regulations and negotiations few if any insurers actually pay full charges. Because virtually no public or private insurer actually pays full charges, charges are an unrealistic standard for comparison. A more realistic standard is what insurers actually pay and what the hospitals have been willing to accept. That should be a standard of comparison to see if the amount paid is reasonable.

The amount charged is determined solely by one party in the transaction - the hospital. It is not a market transaction. The amount paid that is determined by both parties in the transaction is a reasonable amount. These are the rates determined in a negotiation between insurers and hospitals.

Self Pay Patients

In 2006, only three groups routinely paid full charges. The three groups were: (1) the uninsured, (2) international visitors and (3) some health savings accounts that carry a high deductible. Together these are commonly known as "self pay" patients

Because the federal government, state governments, private insurers, or managed care plans do pay full charges, the regulatory and market constraints on hospital charges were virtually eliminated**.** Each insurer has developed a different way to pay hospitals; this lead to a phenomenon known as "cost shifting". The self pay patients continued to pay higher and higher charges as hospitals "shifted" costs to self pay patients.

Between 1960 and 2006 hospitals began increasing their charges much faster than their costs. The reason is that market forces were not holding down charges. The greatest acceleration occurred after 1995. This can be seen by examining the ratio of charges to costs and by examining the rate of increase in hospital charges compared to the rate of increase in hospital costs.

Self pay patients have virtually no bargaining power. A patient with an emergency does not have the ability to compare prices and comparison shop. They are likely to go to the nearest facility or where the ambulance takes them. During an emergency situation the person or their family cannot bargain or negotiate. The provider has all the power.

Most visits are not emergencies and so it would be possible for self pay patients to comparison shop. However, the ability of a person to negotiate with a hospital or physician is very limited. For the reasons stated earlier the self pay person does not know what services he/she will need with any certainty and therefore would not know what prices to compare. Going to a doctor or going to a hospital is not like going to the Wal-Mart and filling your shopping cart. In the medical setting you do not select the services and you do not know what services that you will need until you receive them. A person contemplating open heart surgery, a person with diabetes, a person with a pain in their

hip will not know what services they will need and cannot therefore realistically compare prices.

The relative bargaining power is totally skewed in favor of the provider for a self pay patient. ***I have read numerous depositions where a self pay patient needed hospital care and tried to negotiate a discount off of list price. In virtually every case the person was turned down***. Some hospitals have a discount policy for self insured patients but it is often very complicated for the person to access. ***The rates that self patients pay are often three times the rates that health plans are paying. Health plans pay a rate that is generally 10-20 percent above cost, not 100 – 300 percent above cost.***

Ratio of Charges to Costs

The most common way to examine the relationship between charges and cost is by the ratio of charges to cost. It is a routinely used statistic in the hospital management and hospital finance literature. As the ratio between charges and cost increases, the divergence between charges and costs increases. A ratio of 3.0 means that charges are three times costs. This suggests a 200% profit margin if the patient pays the full charges.

Table 1 shows the ratio of charges to cost by state for 2000-2003. In 2003 New Jersey was the state with the highest ratio of charges to costs. According to table 1, the ratio of charges to cost for all hospitals in New Jersey was 4.51 in 2003. In other words, the average hospital in New Jersey was charging $4.51 for each $1.00 it cost. This is a 351% profit margin.

Maryland has the lowest charge to cost ratio. Since the mid 1970s Maryland has been regulating hospital prices and not allowing the ratio of charges to cost to exceed certain values. In Maryland the prices for self pay patients are the same as for people with health insurance, only Medicaid gets a slight discount.

Table 1 also shows that charges were increasing much faster than costs in most states
during the 2000 -2003 period. The relationship between charges and costs was continuing to erode over this time. In New Jersey, for example, the ratio of charges to costs increased from 3.16 in 2000 to4.51 in 2003. In other words, the markup over costs increased from 216 percent to 351 percent over a three year period in New Jersey. Other states had similar increases in their ratios of charges to cost.

What Can Be Done To Improve Price Transparency?

Patients cannot ever understand the 10-50,000 items on the charge master file. Also it does not make sense for them to examine all the items on the charge master file when they will only need 10-500 items. The same holds true for the 10,000+ CPT codes that physicians use. There needs to be a way for hospitals and physicians to signal their relative prices.

When each hospital and each physician has complete discretion to establish its own price list, it will be impossible for the patient to do comparison shopping. Because they do not know what services they are going to need, they cannot be good comparison shoppers.

Also because each hospital and each physician has discretion to set the rates for each individual service, it is difficult to determine if the prices are reasonable. If there were one basic price list, then it would be possible to easily compare prices. Not all insurers would have to pay the same rate but they would use the same set of relative prices.

One possibility is for the hospitals, physicians and other providers to say that their prices are X% of the Medicare rate. One hospital could say that they accept 125% of the Medicare DRG rate. They would accept the same percentage above or below the DRG rate for all DRGs unless they explicitly made an exception for certain DRGs. Another hospital could accept 120% of the Medicare Prospective Payment rate.

For physician services a physician could say that he/she charges 125% of the RBRVS rate. The physician could say that for certain procedures he/she charges more or less than 125% of the Medicare rate. The same principles would hold for other providers. The providers would announce their prices with reference to Medicare rates.

This could solve both problems that I have mentioned. The patient would know the price of one provider relative to another provider. The patient would not have to know the price for any specific service; instead the patient would know how the prices generally at one hospital compare to the prices at another hospital. Second, ***it would be obvious when a provider set a price that was not in the market range***. It would be obvious that hospitals and physicians are charging patients much more than what insures such as Medicare are paying.

Thank you for the opportunity to testify this morning. I would be happy to answer any questions.

MR. DEAL. Thank you.

I apologize, we are going to have to take a brief recess while we go vote and we will be back and reconvene at that time.

[Recess]

MR. DEAL. I call the hearing back to order. We have several witnesses who need to leave, Speaker Gingrich being one of them, I understand very soon so Members will come as you have noticed, they sometimes come, sometimes they go. Hopefully some will come back.

I will begin the questioning and let me just tell all of you that I think this has been one of the more interesting panels that I have heard because certainly, first of all, the issue is a current and important issue. Your points of view I think have all been well taken and I appreciate that, and I am sure the members of this committee do, too. So let me try to get a handle on some of it though.

First of all, I am a supporter of health savings accounts but as Dr. MacDonald said, if we do not know what we are paying for and we are taking the money out of our own health savings accounts that is one thing we need to know what we are actually going to be charged. The one that bothers me, I suppose even more than that, is we have all heard the arguments that the Government is negotiating the prices on behalf of the government programs, primarily Medicare and Medicaid. The health insurance industry is negotiating their prices on behalf of their insured's. Therefore, the only ones that do not have anybody negotiating for them are the ones where they get hit the hardest. The argument being that we have been squeezed so much by the Government and we have been squeezed so much by the private insurance industry that that is the only place that we can stay alive. Now is there any validity to that argument first of all? Mr. Speaker, what is your take on that?

MR. GINGRICH. Well I want to say again thank you for letting us come and talk today. And I thought the panel was actually very, very interesting and this is a topic that could go on endlessly.

I just want to start with a very important ascertation that this system is a mess. Any time you go to somebody that is trying to pay the bills at a hospital, at a doctor's office, at a pharmacy, a pharmaceutical company, or you name it. They are always going to have reasons inside this system that are perfectly reasonable because they get up every morning saying how do I maximize my revenue in a system that is a mess? So everybody has good stories. I mean if you have malpractice litigation reform, prices can come down. You see that in Texas and Missouri right now. If you have other kinds of reforms, prices can come down. So the last suspects who are unable to defend themselves are small businesses and the uninsured. Small businesses and the uninsured both get gouged and that is just a fact.

But in a true market where price transparency was available and quality information was available, people would in fact rapidly migrate to less expensive better solutions. In airlines, the price has dropped from .23 a mile in 1979 or '78 in constant dollars to .12 a mile in 2003. Now that is a breathtaking change and the average American today can fly more places at lower costs than any time in history, and as a result more people fly. So I would argue that until you decide you are really going to be in a market, and, it is going to be. Look, I used to represent Delta Airlines, Eastern Airlines, Southern Republic, PanAm, go down the list. It is very painful to make a transition from a regulated secret operation to an open market operation. I will tell you, it is going to be painful in the health field too, but in the end you are going to get better results for more people and I would take the money saved on waste and fraud and I would turn that money into tax credits so that every American of every income level was inside 100 percent. I am for a 300 million payer system where every American has insurance coverage. You can afford that if you take the waste and fraud out of the system. You cannot afford that inside the current system.

MR. DEAL. Yes, Dr. Goodman. Push the button down.

MR. GOODMAN. If an uninsured person goes to the hospital and gets emergency care, there never was a contract and there never was a meeting of the minds. You might consider legislatively determining what a fair price is. It might be what the cost is paying. Or if the hospital is getting a significant disproportionate share of money, you might say that a fair price is the Medicare price or the Medicaid price whichever is lower. If an uninsured person goes in for elective surgery again, if there is a meeting of the minds and agreement on price, that is fine, but if there is not, again you might go back and rely on some legislative benchmark of what is a fair price.

MR. DEAL. Dr. MacDonald, I am very intrigued by what you have done and I apologize that I am running out of time. Maybe we will have

some time for more questions but, you know, it seemed to me in the whole context of this that if you are paying cash or paying out of your pocket or reaching into your health savings account and that is the source of the money, it is not going through all the bureaucracy of having to file the insurance claims and having to argue with the insurance company as to whether this is appropriate or that is appropriate. You know it would seem to me that ought to be the cheapest customer because they have cost you less in overhead. Am I wrong?

DR. MACDONALD. No, you are correct. And actually that is part of the problem with the HSAs, I mean you go in and use your HSA dollar, you are paying retail price not wholesale price. So it should not be a surprise that people with a high deductible are not pursuing care. A lot of people are missing the point. They are using high deductibles as the deterrent to care. Well the deterrent to care is paying ten times what is accepted from an insurance carrier. What I do not consider is places like California. Take the frequent flyers in the emergency room, the people that are coming in and they do not understand, attach them with mentor. Get dollars currently being spent in Medicaid or Medicare, whatever pot you want and let us look at those dollars. Track them, qualified medical expenses, only so it is not beer and pretzels that they use the money for. It is real things, and let us see if we can make an impact on the frequent flyers in the emergency room. A lot of people think they are the reason for the high cost and that is not true. Cassil in my briefing, I referenced the article you can look at it and see. They looked at the emergency room visits for about four years, 16 percent increase, 66 percent were Medicare and those with insurance, ten percent for those without insurance. The burden to care is not a high deductible policy. The burden to care is the reality if it is confusing. And I am glad the gentleman had spoke, they do not understand 25,000 lists, master lists. Well they do not really care, and you do not care either. You only care about the one thing that is on your list. See no one in this room cares about 25,000 doodads. They really do not. You only care when you get sick and you see that bill. That is what you care about. I mean, you pay with a dollar that swipes and it is gone, you should not pay the administrative burden.

MR. DEAL. Mr. Pallone?

MR. PALLONE. Thank you, Mr. Chairman.

I wanted to ask either Dr. Anderson or Dr. Collins or both of them a question that relates to my poster. They have seen my poster before about buying two stents and you get free same day installation. I developed this basically to highlight to absurdity of trying to transform the health care market into other types of commodity markets. And reality is you cannot treat health care like a simple commodity in my

opinion. But that is what I wanted to ask you. I mean, do you think, can you treat health care like a simple commodity? I mean part of the problem is the tremendous amount of uncertainty that exists within health care. It is not like going to buy a car and saying you want to pay X amount of dollars to get power steering and power brakes. That is my opinion but that is what I want to ask you. In other words, you know, do you think we can look at this like a simple commodity? Do you think we can look at it in the way that we buy a car or, you know, get power brakes? And are there other unknown variables that may factor into the price?

DR. ANDERSON. When you go and buy a car, you can kick the tires, you can look at the power steering, you can make all those decisions. When you go to the doctor, when you go to the hospital, you cannot do all that because you do not know what services you are going to need until you actually receive those services. So to take your stent example, you do not know which of the many stents you are going to use so you could not do comparison shopping to say I want this stent or that stent. You do not know clinically which stent is the best you have got to rely on your doctor. He or she is going to make those decisions for you. I had the privilege of being on 60 Minutes last Sunday and the stent example was used actually in a particular hospital and they were charging, they essentially bought it for less than $10,000 and were charging the patient $50,000 so they had a markup of basically 5 to 1 on this particular stent. But as a consumer, I would not know whether $50,000 was the appropriate price or $10,000 was the appropriate price. I would not even know whether or not I was going to need a stent until I showed up at the hospital and my doctor said that is the way that we are going to treat your heart attack or that is the way we are going to take care of your veins. So it is much more complicated than buying a car.

MR. PALLONE. Dr. Collins?

DR. COLLINS. Patients are really in the weakest position really to demand lower prices and higher quality from their providers. Accrediting organizations, the Federal government, State governments are in a much stronger position to negotiate prices. It is really unreasonable to think that this market is ever going to function like markets for other goods and services. It is far too concentrated both on the insurer side and also on the provider side. So we really need to look at different ways to solve both the quality and the cost problem.

MR. PALLONE. And she brings me into the next question which relates to individual consumers not having, you know, the ability to negotiate, you know, discounts on provider payment rates. In other words, the individual versus, you know, large volume consumers. And I wanted to ask Dr. Ginsburg, you know, basically that. There seems to be

some idea that consumers, particularly the uninsured if they know the actual price for a medical procedure will be able to negotiate a better rate with a provider of their choice. But Dr. Ginsburg, that seems to fly in the face of what we know about how markets work today. Discounts are granted based on volume for the most part. And one side to an individual in need of an appendectomy for example does not have a lot of leverage to try to negotiate a better rate for that procedure. So I wanted you to comment on this. How well are consumers going to be able to negotiate discounts on their own? Isn't that what insurance is supposed to do?

MR. GINSBURG. I agree with you that consumers are in a very weak position in medical care and other markets to actually negotiate. What consumers can do is if they are aware of the prices and different providers, they can decide to go to a provider with a lower price. They are more likely to do that if they not only find, but have good price information but if they have information on quality which usually is not the case.

The key thing in this area is that uninsured people have very different needs than insured people. For the most part insured people have their insurer negotiating for them and for all the other enrollees so that if you are considering whether Government should do something to increase price transparency, the focus should be on uninsured people and so just to make it easier for them to compare, not to negotiate but to make comparisons across providers.

MR. PALLONE. And just to, I do not know if we have time for this, Mr. Chairman, but one of the health care proposals that we wind up discussing this year is association health plans. And the premise behind those is by allowing small businesses to band together, they can negotiate better prices largely exempt from consumer protection laws. Now isn't the premise there exactly the opposite of what many who would also support AHP's are arguing today, that it is the individual would could potentially negotiate the discount. The whole premise is the opposite, it seems to me.

MR. GINSBURG. Yes, that is right. I think the motivation, you know, that is stated is the combining and being able to, I mean, larger groups do get better rates for health insurance. That is well understood. And the notion is that by smaller groups coming together into a larger group they can get a better rate. And there are a lot of other things involved with the association health plan issues such as risk selection and whether you are going to form a pool of healthier than average people, get a better rate on that basis and wind up in a sense imposing costs on people not in your pool.

MR. PALLONE. Thank you.

Thank you, Mr. Chairman.

MR. DEAL. Chairman Barton?

CHAIRMAN BARTON. Thank you, Mr. Chairman.

Mr. Speaker, in your remarks you talked about health care being a commodity like any other commodity. When I took economics way back in the '70s, my recollection is that my economics professor indicated that health care was a little bit different kind of a product. That it wasn't a pure commodity because it actually affected people's health and was just a little bit different. So do you want to elaborate on that?

MR. GINGRICH. Yes, thank you for the question. Let me say first of all the term commodity does not simply apply. There are very complex commodities. But the question is does the interaction tend to respond to market behaviors? And so I am going to just say a couple of comments have been made in the last couple minutes. You have very large markets for airline tickets in which individuals get dramatically better choices because collectively they apply amazing downward pricing pressure on the airlines. They do not negotiate directly with the airline, they negotiate with the market. And they say to the market, I am not going to pay this price and the result is prices come down. The evidence is overwhelming, but you can in fact describe most hospital costs and the people can make rational decisions. And again I am not talking about in an emergency room when you are in a crisis whether it is a heart problem or it is an automobile accident, but I would suggest to you that most decisions in health care are not in fact situations of absolute helplessness. In every other aspect of American life where people make complex decisions, what kind of home do you want to live in? What kind of job do you want? How far from your job do you want to live? What kind of car do you want to build? Which kind of vacation do you want to go on? We have amazing complexity even for senior citizens. Senior citizens are allowed to go to Wal-Mart with 258,000 items and nobody has suggested that they are too stupid to go around Wal-Mart, but you get to health and we say gee, people cannot understand this. They cannot understand it because the current system is professionals, bureaucrats, and regulators talking to themselves. So people never make it simple enough, all right? That happened even with the Medicare Part B where the CMS bureaucracy, despite its best efforts, could not talk in a language that would be perfectly normal for most people.

So I am going to start and just say that if you look at general patterns, and there was discussion mentioned earlier, look at dentistry, which is not a simple process. When you go to the dentist's office, the dental assistant is giving you an X-ray and it is being read in real time while you are sitting there and you are discussing with the dentist what ought to happen to your mouth. And people have this conversation every

day. Look at laser surgery. I do think the problem of fraud is real, but that is a commercial market problem with any product. You can have fraud with automobiles, you can fraud with stock, and there is always something that gets fraud because some people are nasty and mean spirited.

CHAIRMAN BARTON. Even if we agree that health care is a different kind of commodity or is not the same as airline tickets exactly or some of the other automobile parts, there is no reason to state that transparency and pricing information would not help. Does anybody disagree with that, regardless of what you think health care is that more transparency is a good thing not a bad thing and price information is a good thing not a bad thing? Does anybody disagree with that?

I hope I did not make the Speaker mad. We do not normally have witnesses just get up and walk out of the room. Yes, sir?

DR. ANDERSON. Well I think that transparency is a good idea at the same time it is very different in health care than it is in other services. So I do not think transparency will buy you very much. In my testimony, I talked about this but let me take Speaker Gingrich's example of Wal-Mart versus health care. In Wal-Mart, you go out with your shopping cart and you make all the choices yourself, you know all of the prices. When you go into the doctor's office or go into the hospital, you are not the person making the choices as to what to put in your shopping cart. When you got E care at Georgetown University Hospital you were not making the choices of which service to get, which stent to get, which kinds of activities and you were not in a position most of the time nor was your family member at that time in the position to make it. So as somebody who still teaches health economics at Johns Hopkins University, I can tell you that at least I am not teaching it as a commodity.

CHAIRMAN BARTON. My time has expired but this I think is worth telling. They asked me as I was going into the surgical room for my operation or incision for my heart attack if I wanted to be sedated and I said not unless you have to. I want to be awake if it is allowed. So they gave me some sort of mild drug to make me feel good, but I was conscious. So I am watching the doctors get ready to put these stents in my heart and they are talking about it and so I did ask the doctor, I said do you mind if I ask you what that stent costs? He said well this stent, it costs, I am not sure but it costs between $2,000 and $3,000. He said we are going to put three of them in your heart, and I said that is a good thing, right? And he said, yeah, that is a good thing. He said I do not want to talk politics with you because he had learned that I was a congressman and I was Chairman of the committee that had jurisdiction over health care, but he said if you were a Medicare patient, Medicare

would only pay for one of these stents. He said now we practice the best practices of medicine. You need three and we are going to put three in your heart, but if you were a Medicare patient, Medicare would only pay for one. I said we will change that, and we are trying to change it. I may have changed it, and do not know it because since I had my heart attack I did not finish the final negotiations on the Medicare/Medicaid budget reform package but I instructed that we change it in that package. So even on the operating table I was asking the cost question but I did not say do not put it in because it costs to much, I said put all of them in you need.

I yield back, Mr. Chairman.

MR. DEAL. Where did you send the bill?

CHAIRMAN BARTON. Blue Cross Blue Shield.

MR. DEAL. Ms. Capps is recognized for questions.

MS. CAPPS. Thank you, Mr. Chairman.

And thank you each of you. I am sitting here very frustrated and I will come out with my bias as having a background in public health in just a minute. But I want to associate myself with the Chairman's remarks. Mr. Barton, when you were willing to sort of own up to your experience, both in your opening remarks and now, it seemed to fly in the face of a lot of the discussion about free market commodity and all of this; but I agree with you. If we are talking about health care as a commodity, it certainly is a very complex and service laden quality based situation we are talking about. And Dr. MacDonald knew I was frustrated too and he, as provider of care--and I have a lot of respect for family physicians--and there is something about being on the front lines and seeing whatever comes in the door and understanding what you acknowledged to me personally. And the Speaker also said this is a broken system and we have too many people on the panel, and we are taking on too many topics. Transparency is a good thing. Health savings accounts are an important discussion point but they are not going to save health care. They are not the solution. I am not a big fan because it skims off a lot of people. When Mr. Gingrich got up and left I was going to say, you know, a lot of people luckily can talk about choosing their home, choosing the credit card they are going to buy, choosing their job. But what about the people who never have those kind of choices who also need health care who are barely lucky to be able to rent, who get the job that nobody else wants, and cannot afford--here is where my bias comes out. I remember when managed care came to California. I have been a nurse there all my adult life before I came here and it was non-profit, it was Kaiser. And it was effective to me in that it allowed people in the plans, it incentivized people to do preventative health care, to lose weight, to change. The most important thing we should do as a Nation is

to give people incentives to practice the behaviors that will lower their health care costs and keep them out of the hospitals where it is very expensive to get health care. But I have watched managed care do a number on my State in my area and there are not any programs left because it became profit making and they could not afford to do all those things.

But I am concerned about one aspect of medical savings accounts because it seems like if people choose a savings account, they are going to choose a high deductible plan. Most of us think we are not going to get sick. Dr. Collins, I will pick on you but anybody else can jump in if there is time. When the people choose high deductible plans, what does that say about the public health system at large and about doing the kinds of things that will be the most cost effective as a Nation providing care or receiving care?

DR. COLLINS. The Commonwealth Fund sponsored a survey with the Employee Benefit Research Institute where we did a nationwide survey of people who had both comprehensive plans and also people in consumer driven plans, plans with high deductibles and no savings accounts and plans with high deductibles and savings accounts. What we find is that people in the plans have much higher out of pocket costs in the plans being the consumer driven plans or high deductible plans have much higher out of pocket costs than those in the more comprehensive plans. Most worrisome is that we do find that people when asked if they skipped care, avoided care, delayed care because of the cost when they were sick. People in the high deductible plans, in the consumer driven plans, the plans with savings accounts and without were much more likely to say yes to that question. So there is some evidence that people are avoiding the kinds of care that they need to keep them healthy over the long term. We also asked about prescription drugs. We asked if other people had skipped those just to make their medication last longer.

MS. CAPPS. Right.

DR. COLLINS. If they had not filled a prescription because of the cost and we find the same thing. With a particular, the problems particularly pronounced among people who have health problems and low-incomes.

MS. CAPPS. I hate to be so rude to see if anyone knows are there studies that demonstrate that this actually adds to the cost of health care for this Nation by people doing this, by seniors? I mean that is what I would like to find out. If we are talking about fixing a broken system, a system that is way too expensive, is there anybody who knows of studies that when people do not get the care they need because they cannot afford the high deductible, where is that cost going?

DR. COLLINS. There was a study done by Tamblyn that looked at whether people who had high out-of-pocket costs reduced their prescription drug use and they found that they did and that there were adverse health consequences as a result of that.

MS. CAPPS. Which could be more--could Dr. MacDonald just--he wants to answer that.

DR. MACDONALD. Well the Rand data is contrary to what you said in that when people had control of their money, mothers would pursue preventative care, immunizations, and routine care so there is data to support contrary to what your study showed. In my experience with Medicaid patients, many came in to see if I could help them pay for the medication. We actually worked on ways to get rid of the medication. So my practical experience of seeing people without money, they would ask how can we get rid of the need for the medicine.

MS. CAPPS. I just submit to you that a lot of them came to me as a Member of Congress and said they cannot take their medicine and, they did not have a doctor who would work with them like you did. So I think we need more information.

Okay, well I went over my time.

MR. GOODMAN. Well the Commonwealth study was a really bad study because it confused the difference between a high deductible plan which was in the market for decades, and plans in which people actually managed their own health care dollars. All reporting for the industry is when the health savings accounts are funded, when people have the money there, they get more preventative care than under traditional plans and they do quite well and there is no evidence that they skimp on needed care. There is evidence that they skimp on or cut back on unneeded services, have fewer unnecessary trips to the doctor, and fewer prescription drugs.

MS. CAPPS. Okay.

MR. GOODMAN. Especially from brand name to generic.

MS. CAPPS. Right, so those who are in the savings accounts but again I come back to the point that a lot of people have never, so many people do not have a savings account at all and this is a moot point for a lot of the people that I represent in my congressional district.

MR. DEAL. Mr. Shimkus is recognized for questions.

MR. SHIMKUS. Thank you, Mr. Chairman.

This is really a telling hearing because it does highlight a huge difference between protecting bureaucracies or the Government versus empowering individuals and giving them choices. One of the benefits of health savings accounts is where you have 44 to 46 million uninsured Americans. I think most Americans are concerned about catastrophic issues. With health savings accounts you would make catastrophic

coverage more affordable for everybody. And that is a fact. And then so the question is that I would like to in talking about this Dr. MacDonald, how much of the health care costs are in these emergency room aspects, the emergency visits of all the health care costs what is the percentage of that?

DR. MACDONALD. I do not know the number, I just know in the emergency room.

MR. SHIMKUS. Yes.

DR. MACDONALD. I thought this discussion was what was the cost. I am confused because I think we are distracted into an HSA discussion. I thought we wanted to talk about what is the cost. What is the cost in the ER, it is inflated about ten times what is accepted from insurance carriers. The uninsured cannot bear that bill so what is the percentage, I am not sophisticated enough to know that number.

MR. SHIMKUS. Well ask around, let us follow up on your comment then.

DR. MACDONALD. In the emergency room, the average bill right now for the insured is about $400 to $500 starting plus whatever goes on top of that. When the insurance carrier coded the right visit 99C85, $149 is what they pay.

MR. SHIMKUS. See I am from the Midwest, from Southern Illinois, a rural area where people still want to pay their bills and people will do all they can to make sure they pay bills do. If they have no coverage and if they have an inflated emergency room cost, do you think that is a system which would encourage them to try to pay their costs, or if it is inflated by ten fold, what would the person with moderate to no income, what would they probably do?

DR. MACDONALD. I have talked to a lot of administrators, hospital administrators, who write it off. I have looked at the 5500's of a lot of hospitals and if you analyze and scrutinize the 5500 which is the tax reporting and see where all the money is going, it has been a very interesting event for me. I have learned things that I did not want to learn and that is when people say they are not making money. Look at the 5500's and you will see what non-profits are doing. I think the non-profit status needs to be reevaluated because someone goes to the ER and gets a bill they are not going to pay it. They are just not going to pay it. They are going to write it off or go to collections or get a judgment. I have been in the courtroom with people that are having judgments put against them by a non-profit hospital for a bill that is ten times what is accepted for an insurance carrier. It has just got to end.

MR. SHIMKUS. One of the reasons why I kind of try to stay off this committee for a couple cycles was the funding aspects of health care is just too confusing and it is. What I have come to the conclusion is such

cost shifting that does, it is the uncompensated care, all these millions of uninsured, people claiming that they are writing off and they are writing off inflated costs, that is why the transparency debate. What is the best model to clean up waste, fraud, and abuse? And I would like--go ahead, sir.

MR. GOODMAN. This is not confusing in those areas of health marketplace where third party payers are not paying most of the bills. If you went to a Target Store in the upper Midwest in a shopping mall you would see a list of prices. You know exactly what you are going to pay. I would bet that those prices that are being charged to people in Target Stores are less than what Blue Cross pays and I would bet they are even less than what Medicare or Medicaid pays. So markets really can work, people can shop, and people can compare prices for a lot of health care services and there is no reason to deny them this opportunity.

MR. SHIMKUS. And we see some of this already. I would like to claim the name of a former colleague, Dr. Greg Gansky who served with us here. He is very knowledgeable, and was great on the Health Subcommittee. Who can answer the question of as far as LASIK surgery or elective plastic surgery one that is not in essence regulated, how has a competitive model worked in those two areas?

MR. GOODMAN. It is very good. Over the decade of the 1990's, the price of all cosmetic surgery, the real price went down.

MR. SHIMKUS. Even Dr. Gansky would--I have heard him say that a number of times as a Member of Congress because that is the type of medicine that he practiced.

MR. GOODMAN. For every other surgery we are getting 10 percent a year increases where prices are going up and down in real terms in this market and even though we have all kinds of technological innovations, huge surgeon demand, huge surgeon procedures, this is a market that works like real market, people get prices. The thing that I think that needs to be emphasized here is you are not getting transparency because anybody negotiated for it or because anybody regulated it. You are getting transparency because markets are always transparent when they have to deal with consumers spending their own money.

MR. SHIMKUS. And my time has expired, Mr. Chairman, I yield back.

MR. DEAL. Mr. Green you are recognized.

MR. GREEN. Thank you, Mr. Chairman.

And following my colleague from Illinois, I can understand the concern about, I like to empower an individual. The problem I have is most insurance spreads the risk. So I can buy a high deductible for my auto insurance and save a lot of money. How many people have $5,000 for their auto insurance for, you know, if they have an accident? You

know they may have $250, $500, maybe $1,000. But we are talking about a $5,000 deductible for health care and you are spreading that risk. If I am healthy, then I am probably going to want an HSA and have the income to be able to put that money aside. But if I am not, if I am a blue collar worker that has to pay those every month or the employer requires him to pay monthly, HSAs are really not going to be helpful to them very much and I think that is what a lot of the studies that I have seen. But I like the idea of, and that is the focus of this hearing is, transparency. I have no problem with transparency.

And I will follow up on our Chairman who really did not have a choice on his stents because it was emergency. But I was diagnosed up here two years ago that I needed to have a CAT Scan, and because I might need stents, I said well wait a minute, it is going to take me five days if that is going to happen? My family is in Houston, I have two great heart facilities there with both Dr. Cooley and Dr. DeBakey. I said I am going to go home. So I went home. Admittedly, I did not call Dr. Cooley and ask him by the way, how much will you charge for my CAT Scan or call Dr. DeBakey at Baylor and compare to UT. I did not do that. I called my daughter who said the best one she thought would be Dr. Cooley because she is also a UT doctor. But be that as it may, I do not thing consumers can make that even when they have that choice. Now, and that is what bothers me, but I like the transparency because in all honesty it works for the things that are elected. LASIK surgery, I wear glasses most of the time. I have not wanted to do LASIK surgery because I do not know of the comfort level of me not wearing glasses would be worth whatever risk, the concern I have about the process. But it also does not always work when you have children because again having two children that grew up, you know, we wanted them to go to their pediatrician. I do not know if my wife would have been willing to shop around for pediatricians that charged $25 instead of $30. She went with a pediatrician that was recommended by her OB-GYN. And so again, I like the transparency and I like to do that but I also do not think that it works, it is the panacea that everybody is looking for. And again, my problem with the hearing is that if we are trying to do transparency and is the next step to show HSAs are really good, I think you have a long way to go.

Let me ask Dr. Ginsburg, one of the other witnesses, Mr. Goodman talks about HSAs as devices to motivate shopping. In fact is it the high deductible plans that motivate shopping while the HSAs delete the incentives especially for high income people because people have what essentially amounts to free cash to spend on their HAS?

MR. GINSBURG. Yes, I agree with that. It is the high deductible plan that qualifies you for an HSA that proves the incentives for you to be

careful in your health care shopping. If you just had a high deductible plan, you would have the sharpest incentives. If you are fortunate enough to have an HSA as well, in a sense the HSA dilutes your incentives because here is money in an account that I can only use for health care.

MR. GREEN. Yes.

MR. GINSBURG. And I also know that if I can afford to and if it is used, I can put more in it and get a very substantial tax subsidy. If I am high income, it is probably worth a 45 percent tax subsidy. So in a sense it is not the HSA which is the cost saving thing, it is the high deductible plan and the HAS, if anything, makes that plan more acceptable to consumers if they are going to have a balance to buffer them.

MR. GREEN. Sure. If you are getting a tax incentive to do it.

MR. GINSBURG. That is right.

MR. GREEN. But we could also encourage and I would hope business, you know, because we are seeing a lessening of businesses providing not only better care for their employees but also attended care, higher cost to the employee based on their care, and also their dependence. But maybe it is Congress and this is not the committee to talk about tax incentives but maybe if Ways and Means look at tax incentives for--that would include these other than HSAs. Sure, let us put HSAs in there but let us also look at other health plans that we could buy instead of making just a regular deduction. We could actually incentivize people to say hey, I want a full service plan because particularly I have two small children and they have to go get shots, it is going to have to do all this.

MR. GINSBURG. Because there is really a lot that can be done as far as thinking through the entire structure of tax subsidies for health care and making them more rational. For example, making greater use of tax credits instead of the exclusion of the employer contributions from taxable income would have some very different distributional effects. And even the HSA, I think a lot of people have complained about the rigidity of the requirements and it has to be $1,000 deductible for individual, $2,000 for a family. I am sure that if the idea is to encourage people to have a plan that leaves them with some incentives to economize in the cost of care, there must be better ways of doing this. In particular if you just specified what I would call the technical term the actuarial value of the term of the plan which basically is the percentage of the bill that the insurance pays. If you just say that we do not want actuarial values above a certain percentage that then would give the insurance industry all the flexibility to come up with benefit structures that are suitable and people like rather than having legislated a very specific benefit structure that some people do not like.

MR. GREEN. Thank you, Mr. Chairman.

MR. SHIMKUS. [Presiding] Thank you.

I would now like to recognize the doctor from the State of Texas, Dr. Burgess.

MR. BURGESS. Thank you, Mr. Chairman.

I appreciate the panel's forbearance for staying with us so long today. I guess I need to make a personal observation too since everyone else is doing it and the Chairman's no longer here. The Chairman of the full committee is no longer here but he needs to understand that the doctor was offering him a sedative before the cath for the doctor's benefit so that he would not ask questions during the cath. At least that is what I always used to do in my practice. I did not do cardiology but it worked in my--

MR. SHIMKUS. Who paid for that sedative? Should the doctor or the patient?

MR. BURGESS. You did on April 15.

Doctor, your story, is a very compelling story and I have actually been in the same place on more than one occasion myself. A patient needed a tubal ligation and we tried to take her to the hospital. It was $12,000. She could go to a surgery center down the street where it is $1,000. It was a pretty easy choice to make. And the question then would come up why am I not going down to the street to the surgery center for all tubal ligations. You ask a very good question in your testimony and forgive me if you covered it and I just missed it but under your points in the end is something to ponder, why can hospitals own physicians but physicians not own hospitals? That is an opinion that we struggle with on this committee a great deal and I thank you for bringing that observation to the committee because while it may not be germane to the discussion today, it is very germane to a number of things that we do take up on this committee. You make another point about eliminating the restrictions for purchasing health insurance across State borders that would be what was described as a blood feud here one night about ten months ago when we marked up a bill to that extent. But again, you just have to ask the question who are we serving here? Are we serving one side or the other or are we serving patients? And I think we cannot understand why we cannot get together and decide on a basic package of benefits that might be offered across State lines and agree on that, tie it up in a nice package and make it available to people.

I had a situation a little over ten years ago where I had a family member, a child, an adult child who was unemployed by choice as it turns out, but nevertheless, it was almost impossible in 1994 to buy insurance for a young single adult. I was a physician, I was willing to write a big check, it did not need to be a little check, I would have paid

for the cost because I did not want the cost of the hospitalization over a car wreck or an accident of some type, a couple of days in the ICU can be absolutely prohibitive to try to pay for that. But there was no product available. Contrast that with now you can go on the Internet, type in health savings account in Google and you have a whole panoply of products that are available to you; some of which cost as little as $55 a month for a person in the 20-year-old age bracket. So there are new tools, and I guess I would just ask the question and Dr. MacDonald, please feel free to start off, but what percentage of people who have health savings accounts would you reckon were previously uninsured that are taking advantage of this?

DR. MACDONALD. Well I would like to preface that with again this discussion is about transparency and cost, and I am not in favor of health savings accounts as much as some are because it is a distorted price. So I want to just clarify that many people are still on the delusion and misconception that group policies are cheaper than individual policies. And having done this for a long time, and check it out yourself and prove me wrong, you can get an individual policy in most States cheaper than the group policy that you are under at your job. Prove me wrong, check it out, send me an email, I would love to hear the response and I have done this because we have a lot of companies. People get insurance, and we help them get insurance. A health savings account is not always the best buy.

MR. BURGESS. Correct. And I thank you for doing it. I am going to interrupt you because the time is running out and I want to ask Mr. Gedwed about our premise here today of course was to talk about some of the legislative products that are out there that could be enacted into law. Do you see in your business and I just got to tell you, I think it is a fantastic thing that you are doing. And really the whole hearing should be about you, sir, but is anything that we are likely to do bothersome to you? Is it going to hurt your business or help your business?

MR. GEDWED. No, I think, Congressman, it is going to help our business. I can tell you today as we talk we are getting really confused a lot. We work with people every day who are single moms who wait tables and cannot afford coverage. The first question they ask us is what can I get in health coverage for this amount of money, and that is all I have available. All we do is give them as much information on quality and price. They now can walk into the provider when yesterday they would charge them $100 per particular visit and they can say well why does the doctor down the street only charge $80? And at that point, the provider gives them a lower point.

MR. BURGESS. Let me just interrupt you there because quickly I want to go to Dr. Goodman.

Do you see any downsize to legislation that we might be doing?

MR. GOODMAN. I think if you require hospitals to post prices that will not accomplish very much at all because if you watched 60 Minutes Sunday night, the hospital association said we have the same price for everybody, the difference is is that some people get huge discounts and other people do not. What I wish you would do is to go back to who owns the hospital. I wish you would appeal the stock amendment or greatly roll it back so that hospitals and doctors can get together on the same team and make profitable improvements in their product and offer package prices. I would like to see us take all the restrictions at the same time off the specialty hospitals. If doctors want to go from their own hospital they can. I would like to see an override of all State laws that say that the hospital cannot charge a lower price to the uninsured than they charge to Blue Cross. So there are some things that you could do that I think would be very, very positive.

MR. BURGESS. Thank you.

Thanks, Mr. Chairman.

MR. SHIMKUS. Thank you.

The Chair recognizes the Ranking Member of the full committee, John Dingell. You are recognized, sir.

MR. DINGELL. Mr. Chairman, thank you for your courtesy. This has been a very useful hearing and I commend you for it.

These questions are for Dr. MacDonald. Doctor, good morning. The question, the first question at least we need only a yes or no answer. Now let me ask you about your view on these matters. You favor and support price disclosure for hospitals, for physicians, and pharmaceutical manufacturers. Is that correct?

MR. GOODMAN. I do not think that kind of legislation will help.

MR. DINGELL. I am sorry?

MR. GOODMAN. I do not think that kind of legislation will be helpful.

MR. DINGELL. I did not ask about helpful, I just said do you favor that kind of situation?

MR. GOODMAN. I do not favor legislation to force imposed prices, no.

MR. DINGELL. My question is a very simple one. I am addressing this question to Dr. MacDonald. Is that your name?

MR. GOODMAN. I am sorry.

MR. DINGELL. Since you have become Dr. MacDonald and I have addressed Dr. MacDonald, I hope you will respond that you were a little bit early. Dr. MacDonald, do I have your attention?

DR. MACDONALD. Yes.

MR. DINGELL. Is there only one Dr. MacDonald at the table?

DR. MACDONALD. To my knowledge.

MR. DINGELL. I am comforted to hear it. Doctor, is it true that you support price disclosure for hospitals, for physicians, and for pharmaceutical manufacturers?

DR. MACDONALD. The cost of reimbursement yes, posting prices is meaningless. The cost of what they receive from insurance carriers is more meaningful.

MR. DINGELL. And is it true that you also support our transparency for insurance companies?

DR. MACDONALD. Absolutely.

MR. DINGELL. Absolutely. Now Doctor, according to a December Health Affairs study, 20 percent of the health care costs are associated with billing and administrative functions of insurers. Isn't it true that transparency in this area would be enormously helpful to enable consumers to pick and choose a better health plan? To pick one that devoted more of the premium to actual health care?

DR. MACDONALD. Yes.

MR. DINGELL. Thank you. Now is it also true that while price disclosure can be good, making it only for hospitals, doctors, and pharmaceutical houses is just another way to help insurance companies to negotiate better prices without assuring that these better prices will do anything other than to increase their profits?

DR. MACDONALD. In my experience that is not true because we stabilize the long term re-insurance cost, renewal rates for the businesses we are trying to help. And if the insurance company does not continue to come through, we get a different insurance carrier.

MR. DINGELL. I sense that you are a man of the most exquisitely trusting character and I am comforted to know that there is a man of that character about especially where it concerns dealing with insurance companies. Now according to one source, United Health Care made a profit of $66,265 per employee in 2005. Aetna suffered along with only $61,217 per employee. Large hospital chain HCA had only a profit for employee of $10,253 in 2005. Now Dr. MacDonald, isn't it true that given this information, insurance companies are doing splendidly and if we are really concerned about where our health care dollars are going maybe we should be looking at insurance company disclosures as well?

DR. MACDONALD. Yes, sir. If you stop watering the plant, it dies.

MR. DINGELL. So you do think we ought to require a measure of helpful disclosure by insurance companies?

DR. MACDONALD. Absolutely. We actually are getting that, we are getting disclosure and competition.

MR. DINGELL. Good.

DR. MACDONALD. We are not in agreement with the multiple million dollar executive salaries and then going to the hospital and they are getting a better price than the uninsured. It does not make sense and I hope this committee does something about that.

MR. DINGELL. Thank you, Doctor.

And Dr. Goodman, I will thank you for your assistance. I will try and be more clear next time.

Thank you, Mr. Chairman.

MR. SHIMKUS. Thank you.

The Chair would like to thank our panel today for your patience obviously through debates but also your great testimony has given us a lot of food for thought and we appreciate it. This hearing is adjourned.

[Whereupon, at 1:07 p.m., the subcommittee was adjourned.]

SUBMISSION FOR THE RECORD BY BOB INGLIS

Statement for the Record

The Honorable Nathan Deal
Chairman, Subcommittee on Health
The Committee on Energy and Commerce

Dear Mr. Chairman,

I want to thank you for holding a hearing on the important issue of hospital price transparency. The difficulty in obtaining affordable health care is one of the greatest challenges facing American families. An estimated 46 million Americans are uninsured, and the cost of health care continues to grow far faster than inflation. Our current health care system encourages over utilization of services, restricts choice, and gives consumers little incentive to look for low-cost alternatives (like generic drugs). In other words, it's broken.

Consumer-driven health care models must be part of the fix. By bringing increased market forces to bear on the insulated world of health care, consumer-driven health care models can apply the brakes to runaway growth in health care costs. Health Savings Accounts, for instance, hold the potential to transform our complex managed care system of PPOs and HMOs into a cost-effective system in which consumers turn to the insurance company only for the big things. For the same (or less) money than we're currently spending for managed care coverage, we can (1) buy high deductible (less expensive) policies; and (2) put the remainder in health savings accounts to cover the deductibles, rolling the extra from year to year. Millions of Americans have already adopted HSAs, and millions more are expected to adopt them in coming years.

However, the long-term prospects of consumer-driven health economy depend on our ability to help consumers gain access to accurate and understandable information about the cost of health care services. An increasing number of policy experts are recognizing the importance of increased price transparency in the health care sector. The President has been actively publicizing the need for hospital price transparency in recent weeks; media outlets regularly publish the stories of uninsured consumers stuck with inflated bills after hospital visits; and several states have already passed laws requiring hospitals to make their charges public. Hospital price disclosure is an idea whose time has come.

Ideally, hospitals and physicians would make price lists available voluntarily. In fact, some insurance companies—including Aetna and Humana—are already experimenting with making pricing information available online. These forward-looking companies should be encouraged. However, other providers will need some prodding. As the largest payer in our health care system, the federal government must take the lead.

The hospital pricing system is a labryinthe that traps too many consumers, leaving them wandering and confused. Prices for simple procedures and drugs vary wildly from hospital to hospital, and list prices often bear little relationship to cost. Theseus successfully navigated the original labyrinthe only because he had the help of a magic ball of yarn that led him safely through the maze. Congress needs to act now and provide health care consumers with their own "ball of yarn," a system of easy-to-access information that will help them make cost-effective decisions.

That is why I am pleased to serve as the primary cosponsor of H.R. 3139, the Hospital Price Reporting and Disclosure Act of 2005. This bipartisan legislation—introduced by Rep. Dan Lipinski—would require hospitals and ambulatory surgical centers to report the prices they charge for the most frequently performed procedures and most frequently administered inpatient drugs. The Secretary of Health and Human Services would then post that information on a publicly available, user-friendly website. This bill will not solve all of our health care woes; but increased transparency can only help consumers navigate the twists and turns of America's health care system.

Best regards,

Bob Inglis

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