

**H.R. 4700, THE TRANSPARENCY IN ALL HEALTH
CARE PRICING ACT OF 2010; H.R. 2249, THE
HEALTH CARE PRICE TRANSPARENCY PRO-
MOTION ACT OF 2009; AND H.R. 4803, THE
PATIENTS' RIGHT TO KNOW ACT**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

MAY 6, 2010

Serial No. 111-119



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

76-574

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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**H.R. 4700, THE TRANSPARENCY IN ALL
HEALTH CARE PRICING ACT OF 2010; H.R.
2249, THE HEALTH CARE PRICE TRANS-
PARENCY PROMOTION ACT OF 2009; AND
H.R. 4803, THE PATIENTS' RIGHT TO KNOW
ACT**

THURSDAY, MAY 6, 2010

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

The Subcommittee met, pursuant to call, at 10:05 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Green, Baldwin, Barrow, Christensen, Castor, Sutton, Braley, Waxman (ex officio), Shimkus, Buyer, Pitts, Sullivan, Murphy of Pennsylvania, Burgess, Gingrey and Barton (ex officio).

Staff present: Purvee Kempf, Counsel; Robert Clark, Policy Advisor; Alvin Banks, Special Assistant; Allison Corr, Special Assistant; Mitchell Smiley, Special Assistant; David Cavicke, Minority Chief of Staff; Brandon Clark, Minority Professional Staff Member, Health; Marie Fishpaw, Minority Counsel, Health; Peter Kielty, Minority Senior Legislative Analyst; Ryan Long, Minority Chief Counsel, Health; Cedric James, Minority Staff Assistant; and Kathryn Wheelbarger, Minority Deputy Chief of Staff.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW
JERSEY**

Mr. PALLONE. This meeting of the Health Subcommittee is called to order.

Today we are having a legislative hearing on three bills: H.R. 4700, the Transparency in All Health Pricing Act of 2010, H.R. 2249, the Health Care Price Transparency Promotion Act of 2009, and H.R. 2803, the Patients' Right to Know Act, and I start by recognizing myself for an opening statement.

These three different bills all having to do with improving price transparency in health care are very important in my opinion, and I did want to say that they are in some cases introduced by members of the subcommittee, in other cases by other members, but I wanted to point out that H.R. 4700 is introduced by my good friend

from Wisconsin, Representative Steve Kagen, who we are going to hear from shortly. H.R. 2249 is introduced by two of our subcommittee members, Representative Michael Burgess and Gene Green, bipartisan. And H.R. 4803 is introduced by our full committee's ranking member, Mr. Barton, as well as Mr. Burgess, Mr. Green and Mr. Stupak, again a bipartisan initiative.

Without a doubt, our Nation's health care system is complicated and it can be overwhelming to patients at times, especially when they are unable to make informed decisions. Someone once said to me that understanding health care is like trying to put together a 1,000-piece jigsaw puzzle of a snowy scene in the dark, and the bills we are hearing about today are trying to shine some light on this confusing picture and to help patients and their providers make better decisions. And so I want to commend the sponsors for their efforts to increase transparency and improve public access to information in the health care sector. I believe this is a worthy goal, and if done correctly has the potential to lead to a more efficient health care system.

Providing the right information at the right time and the right setting has tremendous power. It can provide equity in our health care system, something that I know Mr. Kagen cares deeply about and talks about with great passion, not only today but many times on the floor. It can arm patients and providers with the information they need to be make better decisions that will improve quality and achieve better health outcomes.

While I think transparency is generally a good thing, as do many of my colleagues, experts have cautioned us to proceed carefully. They have told us that transparency has its limitations, primarily because health care markets do not function the same way other markets do. They tell us that purchasing medical treatment is not like going out and buying a new TV or a new car. The most costly health care services are often provided in emergency situations or when a patient is unable to make decisions about his or her treatment. And most of our health care dollars are spent on the chronically ill or towards the end of a patient's life. These types of circumstances can limit the ability of transparency to empower patients, lower costs and improve efficiency.

Even in instances where a patient may have the luxury to comparison shop, there are other barriers that they could face. Patients' choices are often limited by the type of insurance plan they have and its requirements. For example, a patient may be able to search for a clinic or hospital that has earned high marks for providing quality care at a lower cost but it might be outside of the plan's preferred provider network. Furthermore, while improving price transparency could help patients make more-informed decisions, experts also tell us that patients trust their doctors and the treatment that they recommend, and patients may not want to go against their doctor's decision in order to find the lowest price.

So the concern, I guess, is about unintended consequences of too much transparency. The Congressional Budget Office has opined on this issue. They have said that the markets for some health care services are highly concentrated so increasing transparency in such markets could lead to higher rather than lower prices because higher prices are easier to maintain when the prices charged by

each provider involved can be observed by all of the others, and the CBO points to the pharmaceutical marketplace as a key example of where this kind of scenario might play itself out.

So as we talk about improving price transparency, I think it makes sense to be cognizant of these concerns. Also, I think it is important to note, as many of our witnesses do in their testimony, that more transparency is just one component of a larger strategy designed to improve our health care system. Arming patients with the right information is tremendously important but making sure that patients are able to access the care they need is of equal if not more importance, and the health reform law that was just enacted will go a long way to make sure that people will have quality and affordable health care coverage and can access the care that they need.

I also wanted to mention about health information technology because it can play a significant role at building a more efficient health care system and it goes hand in hand with the calls for greater transparency. HIT can improve the flow of information between patients and providers. While too few physicians and hospitals use HIT or electronic medical records today, the American Recovery and Reinvestment Act makes a significant investment in encouraging our Nation's physicians and hospitals to modernize their systems and share information.

So again, I want to thank all the members who have introduced bills on this issue. I think improving transparency can be a powerful tool that can dramatically improve our health care system and empower patients and their doctors. We just have to make sure it is done correctly, and I am looking forward to the testimony.

I will now recognize our ranking member, Mr. Shimkus, and then we will go through the remaining opening statements. Thank you.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Chairman Pallone, for holding this hearing on an important consumer right-to-know issue in the health care delivery system.

Whether taking the kids for their annual checkup or getting an MRI, the true cost of health care services is nearly impossible to come by for the average every day consumer. I challenge anyone here today to make calls and shop around for the best price the next time they need to see a doctor. See what it would cost if you paid cash. You will hear silence on the other end of the line. The reality is, most of the time this information and pricing are not made available to patients seeking care, and patients rarely ever find out the true cost of services. Without this information, we take the power away from consumers and prevent a market-based health care system from functioning. Transparency will drive costs down, determine quality and help consumers decide the best value at a price they are willing to pay.

The bills before the committee today are all steps in the direction of empowering the consumer with information. I look forward to hearing the perception of our witnesses on the issue of transparency. I particularly want to thank our colleague, Representative

Steve Kagen, for taking time out of his day to testify. I appreciate the bills cosponsored by colleagues on this committee.

I also want to mention my colleague, the Democrat from Illinois, Mr. Lipinski, who has worked years on bringing transparency issues to the forefront. While it is disappointing his legislation, H.R. 2566, isn't before the committee for consideration today, I would ask unanimous consent to submit for the record a statement from Congressman Lipinski on his bill.

[The prepared statement of Mr. Lipinski follows:]

Statement of Congressman Daniel Lipinski (IL-3)
 Committee on Energy and Commerce, Subcommittee on Health
Hearing on H.R. 4700, the Transparency in All Health Care Pricing Act of 2010; H.R. 2249, the Health Care Price Transparency Promotion Act of 2009; and H.R. 4803, the Patients' Right to Know Act
 May 6, 2010

As health care costs continue to rise, families continue to struggle 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. That is why the first bill I introduced in Congress was H.R. 1362, the Hospital Price Disclosure Act of 2005, which required every hospital to give consumers clear, concise information about what it charges for common procedures and medications. Every Congress since then, I have introduced a version of this bill, most recently H.R. 2566, the Hospital Price Transparency and Disclosure Act of 2009. Because when it comes to health care, information is power.

Most of us would not consider getting our car repaired at a shop 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. Six years ago, I was involved in a serious bicycle accident. Breaking my hip was the most serious shock, but like anyone else who has spent 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 Walgreens you can get a tube 32 times the size for about seven dollars.

The Hospital Price Transparency and Disclosure Act will make price information available for all hospitals and ambulatory surgical centers across the country, giving Americans the ability to make informed choices about where they seek medical care and helping to drive down surging health-care costs by fostering competition. It would mandate that hospitals and ambulatory surgery centers regularly inform the Department of Health and Human Services of the prices they charge for the 25 most common inpatient procedures; the 25 most common outpatient procedures; and the 50 most frequently prescribed medications. HHS would then post the price information online. In addition, hospitals and ambulatory surgery centers would have to post notice in their facilities that the data is available online.

In May 2009, my bill was endorsed by Consumers Union, the independent, nonprofit publisher of *Consumer Reports* magazine. Consumers Union has stated that H.R. 2566 "should help introduce an element of competition into the setting of charges and result in lower billings to patients, particularly in those cases where an area hospital's charges are most out of the norm."

While 33 states have proposed legislation or enacted laws requiring hospitals to disclose their pricing information, funding shortages have prevented many states from establishing databases to publish these data. In the states that have successfully

implemented medical pricing databases, recent studies suggest that consumers have utilized data when making choices about providers and hospitals, and this has ultimately reduced medical costs. Having urged that H.R. 2566 be incorporated into the House health care reform bill, I was pleased that the bill included a hospital price transparency provision. Unfortunately, the Senate health care reform bill did not contain similar language.

The fact is that prices vary widely among hospitals. When California implemented a price disclosure law it found that one hospital charged \$120 for a chest x-ray while another charged more than \$1,500. And while a Tylenol capsule was free at one hospital, another charged more than seven dollars.

At a time when we have more information than ever at our fingertips, health care costs remain largely hidden from view. We can shop online for everything from airline tickets to clothing, yet it is difficult to do the same with medical care. It's time we changed that and gave every American the ability to make better-informed health care decisions for themselves and their families.

Mr. PALLONE. Without objection, so ordered.

Mr. SHIMKUS. Thank you, Mr. Chairman.

But our transparency discussion in this committee shouldn't be confined to pricing health care. Another week and another missed opportunity to hold a hearing to bring about transparency on issues we already know exist in the new health reform law. As Chairman Waxman said just last week, we can walk and chew gum at the same time. We have done a lot of walking since the health reform became law; time to start chewing.

And yet again, we have even more new questions to add to the list of reasons why we must hold hearings on this new health reform law. Is the recent CRS memo correct that Congress could be fined up to \$50 million annually by its own health care law if low-paid aides apply for government subsidies to help pay for their health care costs? Will State and local governments be subject to fines as well? Is it even constitutional for government to pay fines to the government? Why do three-quarters of CFOs recently surveyed believe that health reform law will be bad for America and bad for their companies? Why do those same CFOs expect their costs to increase more than 8 percent over the next 12 months as a direct result of this health reform law? How is this bending the cost curve down as promised by the President and the majority? And for the workers of these companies, 60 percent of CFOs said they will increase copays. Forty-eight percent believe they will have to reduce the quality of health care packages they offer employees. Forty-six percent say they will have to reduce overall employee benefits. For all those employees, can we explain how the prospects of paying more and getting less fall under the promise of if you like what you have, you can keep it?

The committee was quick to want to act when companies when John Deere, Cat and AT&T announced their financial obligations, which is worth noting was required of them by law. Given this survey, we will act quickly to bring in company CFOs to explain how this law will affect their business and employees, and what about Secretary Sebelius's comments this week that we must address the shortage of primary care physicians? How does the Administration intend on doing so? Do we face similar problems in specialty care?

Last week, Ranking Member Barton and all Republicans on the committee sent a letter to the majority requesting a hearing on the CMS chief actuary's cost estimate. This request so far has been ignored. We should not only have CMS but we should also call upon Secretary Sebelius to testify on this and other issues we already know need to be reformed in this new health reform law.

Mr. Chairman, the questions continue and the concerns are mounting. The majority continues to ignore all of these concerns, and I would again plead with the chairman to stop ignoring the issues at hand and let the subcommittee do its job and hold hearings on the health reform law or explain to the American people why we are not, and I yield back my time.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Green, is recognized for an opening statement.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Mr. Chairman, I want to thank you for holding the hearing today on the price transparency in our health care system. I have been working on this issue with our colleague from Texas, Dr. Burgess, for several Congresses, and most recently the Ranking Member Barton and Chairman Stupak.

Dr. Burgess and I introduced H.R. 2249, the Health Care Price Transparency Promotion Act of 2009, for several years. This legislation has been endorsed by the American Hospital Association. H.R. 2249 builds on the existing 41 State price transparency systems and requires States on the condition of receiving Medicaid funds to disclose information on certain hospital inpatient and outpatient charges and make this information available for the public. Under this legislation, all types of hospitals would be required to submit the information. It further requires insurers to provide information upon request and estimate out-of-pocket costs for certain health care services within 18 months of the enactment of the Agency for Health Care Research and Quality, would provide recommendations on the types of health care pricing information consumers find most useful to making health care decisions.

Dr. Burgess and I intended to offer this amendment during the markup to H.R. 3200, America's Affordable Health Care for Choices Act, but there was overwhelming bipartisan interest in the issue. During the markup, Chairman Stupak and I worked across the aisle with Ranking Member Barton and Dr. Burgess and offered a compromise amendment that was adopted by this committee on a vote of 51 to zero, and let me remind you, that was on the health care bill.

The original provisions were included in H.R. 3962, the Affordable Health Care for America Act, as passed by the House in section 1783. For several months, Ranking Member Barton and Chairman Stupak, Dr. Burgess and I worked to introduce H.R. 4803, the Patients' Right to Know Act, which was modeled after the original Barton-Green-Burgess-Stupak amendment and has been endorsed by the Ambulatory Surgery Center Advocacy Committee.

The Patients' Right to Know Act establishes requirements on health benefit plans to provide specific information to current and potential enrollees. Covered health benefit plans are defined as plans that are offered by health insurance companies, Medicare, Medicaid, CHIP and the FEBP. The specified information to be disclosed about the plans includes covered items and services and lists of limitations, restrictions, details about the claims appeals process and out-of-pocket cost sharing. This legislation also builds on the original Burgess-Green bill by requiring State Medicaid programs to administer a price and quality transparency program.

H.R. 4803 also requires that no later than 2 years after enactment, States establish and maintain laws that require disclosure to the public and the Secretary of Health and Human Services of information on prices for and quality of certain services at hospitals and ambulatory centers. Although price transparency provisions were included in H.R. 3590, mostly in sections 1002 and 1003, these provisions are primarily focused on insurance plans and the State exchanges through regulations issued by HHS. I believe this

hearing today will allow us to look at several issues we must tackle including whether price transparency programs should be State based or housed at HHS and the type of information that would be useful to consumers to help lower health care costs. These are topics we must address before we can enact meaningful price transparency legislation and I hope our witnesses before us today will be able to provide us with that insight.

And like my colleagues, Mr. Chairman, I would like to welcome our colleague from northeast Wisconsin because he didn't wear his cheesehead today but I know he has one, and I want to thank him for appearing.

Mr. PALLONE. Thank you, Mr. Green.

Our ranking member, the gentleman from Texas, Mr. Barton.

**OPENING STATEMENT OF HON. JOE BARTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BARTON. Thank you, Mr. Chairman. Thank you, Congressman, for participating in this hearing.

I basically want to echo most of what, if not all of what, Congressman Green just said. His chronology of the efforts that have been made by himself and Mr. Stupak and Dr. Burgess and myself on this issue are right on the point. As he pointed out, in my opinion one of the few bright spots in the health care bill that the House passed was the amendment that he and I and Mr. Stupak and Dr. Burgess offered that was accepted, as he said, 51 to nothing. Unfortunately, that was stripped out or it wasn't included in the bill that came over from the other body. There are some patient transparency provisions in the current health care law but they primarily apply to individuals who purchase individual coverage. That is a start but that is by no means adequate in my opinion.

So it is helpful to have this hearing on H.R. 4803, H.R. 4700, H.R. 2249. If you believe the market-based system is the best approach for health care in America, you should be strong supporters of one or all of these bills. You have to provide consumers with transparency with not only pricing information, in my opinion, but also quality information, availability of care information. That just simply doesn't happen under the current system, Mr. Chairman. Health care is one of the few things in America that you basically take it on faith where to go to the hospital, which doctor to request services for and how those services are going to be provided. We don't even buy used cars like we buy health care in America. So this is a good start, Mr. Chairman.

I do want to echo what Ranking Member Shimkus also said. We are apparently not going to be doing a lot on the House Floor this summer. It would be good to go through and try to digest the health care bill that is now the law of the land. Opinion polls generally tend to indicate about a two to one opposition to it. Those of you that are supporters of it, you ought to be able to hold a series of hearings to prove what a good thing it is, and those of us that are skeptics of it will participate in a good-faith fashion and ask questions and point out areas that we think might be improved.

This particular issue you are hearing about today is a good first step. I would hope that one of these bills or some combination of

these bills could actually be marked up this summer and moved. That would be a good first step, good-faith effort that we are going to try to correct the flaws in the current health care law.

And with that, Mr. Chairman, again, I sincerely thank you for this hearing, and I look forward to working with you, Mr. Waxman, Mr. Stupak, Mr. Green, Dr. Burgess, Dr. Gingrey and others to move this particular issue forward. Thank you.

Mr. PALLONE. Thank you, Mr. Barton.

Next is our chairman, the gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I am pleased that this hearing is well received on a bipartisan basis. I think we all want to see greater transparency in the health care system so that we can see that the consumer is well served by having all the information that will help them make decisions. I don't think this issue is the first step. The first step we took when we passed the national health insurance because the first step is to make sure that people have access to care, to insurance, and with that, we hope there will be a competitive marketplace through the exchanges and we hope through greater transparency that marketplace will work.

I want to commend Congressman Kagen for his leadership in this issue. It is an important one, and I am pleased, Mr. Chairman, you are holding this hearing so we can look at it in more depth.

Mr. PALLONE. Thank you, Chairman Waxman.

The gentleman from Indiana, Mr. Buyer, reserves his time.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. I appreciate the fact that you are holding today's hearing.

Before I begin, I would like to ask unanimous consent to submit for the record testimony of the Wisconsin Hospital Association.

[The information was unavailable at the time of printing.]

Mr. PALLONE. Without objection, so ordered.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you.

I would like to give a warm welcome to two individuals from Wisconsin. One is the Hon. Dr. Steve Kagen. Welcome to the Energy and Commerce Committee. And the other is Walt Rugland of ThedaCare, a leading health care system providing excellence and value to folks in the northern part of the state of Wisconsin.

In light of the strong Badger contingency here today, I would like to share with the committee some stories about Wisconsin. Our State is home to a vibrant set of activities related to transparency in health care. In part because of our efforts to share quality measures between institutions, the Agency for Health Care Research and Quality in its national health care quality report once again named Wisconsin a leader in aggregate measures of quality at the top of the ranking of overall performance. In March, our governor, Jim Doyle, signed the health care transparency bill into law. That means that starting in 2011 health care providers will be required to disclose the costs of the 75 most common inpatient procedures

and 25 most common outpatient procedures so that consumers can make apples-to-apples comparisons on prices. The Wisconsin Hospital Association already has in place a voluntary Web site known as Price Point which uses data from hospital systems to compare the cost of various procedures. Through that site, some hospital systems already provide patients with cost estimates before their procedures. And yet much work remains to be done.

ThedaCare is a founding member of the Wisconsin Collaborative for Health Care Quality, a voluntary group of health care organizations which has served as a leader in improving the quality and cost effectiveness of health care for the people of Wisconsin. This group is expanding their existing reporting to include measures of specialty care and episode-based resource use, and in an effort to make this information more salient for the layperson, the group is planning to launch a consumer-friendly Web site later this year. The site will be a destination and a source of information on both quality and price. I am proud of my State for its accomplishments and what lies ahead.

And again, thank you, Mr. Chairman, for calling this hearing. I look forward to learning more about the various pieces of legislation from our witnesses today. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Pennsylvania, Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Mr. Chairman.

The health care sector is unlike any other part of our economy. Nowhere else do we consume a good or service without knowing the cost upfront. Nowhere else are we OK with one person paying one price for a good or service and the next person paying a different, sometimes wildly different price for that same good or service. When I am in the supermarket, I can comparison shop among different brands. I know what a loaf of bread will cost me before I reach the register and I know that the person in line behind me will pay the same amount for that same loaf of bread. Because of the information on the supermarket shelves and on the products themselves, we can comparison shop based on my criteria including quality and cost. This leads to competition and competition leads to lower prices and better quality.

That is not so in the health sector. Patients don't know what their care and treatment will cost and providers don't know how much insurance will reimburse them for those things, and I can't make an educated decision on whether to go to hospital A or hospital B for a routine test, a test that one hospital can be dramatically more expensive or dramatically cheaper than at the other hospital but I don't know that. In no other situation would I as a consumer tolerate this lack of transparency and basic information. Health care is complex but giving consumers the tools they need to make intelligent choices makes it a little less complicated. As a result, we can expect better care and greater efficiency at lower cost.

The bills before us all today all seek to provide that transparency in different ways, and I am proud to be a cosponsor of H.R. 4803, the Patients' Right to Know Act, which is based on an amendment that was unanimously approved during committee markup of the health care reform legislation last year. This bill will require health plans, public and private, to provide enrollees with specific information including what the plan does and does not cover, any limitations or restrictions on coverage, how to appeal a coverage decision, all cost-sharing requirements, the number of participating providers, what the plan spends on administrative cost, how the plan combats waste, fraud and abuse, and other information. Health plans would also have to provide the total of all out-of-pocket costs for a particular service provided by a specific provider along with quality data. Armed with this information, we can all make better choices for ourselves and our families. Transparency is vitally needed in health care, and I hope this is not the last time our subcommittee deals with this issue, and Mr. Chairman and Mr. Waxman, we still hope that you will have the CMS chief actuary, Mr. Foster, to a hearing of our committee or subcommittee on the cost estimates of the health care law.

Thank you, and I yield back.

Mr. PALLONE. Thank you, Mr. Pitts.

The gentleman from Georgia, Mr. Barrow, will waive an opening. Next is the gentleman from Oklahoma, Mr. Sullivan.

OPENING STATEMENT OF HON. JOHN SULLIVAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. SULLIVAN. Thank you, Chairman Pallone, and thank you for calling this legislative hearing to examine several pieces of legislation, legislation seeking to improve transparency of health care pricing in the marketplace.

While these bills are important, I would like to remind the chairman that there is a pending request from Ranking Member Barton before Chairman Waxman requesting a hearing on the new health care law from the CMS chief actuary. Last week, I along with my colleagues on this committee, sent a letter to Chairman Waxman requesting a hearing from the CMS chief actuary to testify about his recent report on future effects of the new health care law. This new report confirms what many of us have been saying all along: The cost of this new law far exceeds the numbers they used to sell it to the American people. Simply put, Obamacare will drastically raise health care premiums for families and small businesses across the country and it confirms that the new health care law clearly puts our Nation on a path to bankruptcy, limits health care options for seniors and increases the price families and small businesses have to pay for health care they receive. This is exactly why I voted against it.

I encourage Chairman Waxman and the Obama Administration to agree to this commonsense hearing request to allow the CMS chief actuary to testify on these recent reports and future effects of the new health care law. I yield back the balance of my time.

Mr. PALLONE. Thank you, Mr. Sullivan.

The gentleman from Iowa, Mr. Braley.

**OPENING STATEMENT OF HON. BRUCE L. BRALEY, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Mr. BRALEY. Thank you, Mr. Chairman, for holding this important hearing. I would like to welcome my colleague, Dr. Kagen, to the hearing.

I think Dr. Kagen's presence along with our colleagues, Dr. Burgess and Dr. Gingrey, highlights why this hearing on transparency is so important. When they graduated from medical school, the relationship between a doctor and a patient was dramatically different than it is today simply because of something called the Internet. When they graduated and completed their residencies, they had patients coming into their office talking to them about the administration of certain medical procedures and what was in their best interest and rarely did a patient come in having done 5 days of research on complex medical terminology and procedures before they went to meet with their doctor. So those who say that transparency in pricing is not an important component of health care delivery in the future don't appreciate that critical distinction.

Medical consumers are much more sophisticated. That can be a dangerous thing, as every doctor would tell you, but it is a reality, and if they are demanding more information to be part of their treatment choices, they also are entitled to better information and information in language they can understand when it comes to pricing, and one of the witnesses who is here testifying on behalf of the American Hospital Association hits this on the head in the fourth recommendation where he writes in his written statement, "We all need to agree on consumer-friendly pricing language, common terms, definitions and explanations to help consumers better understand the information provided."

That is why I have been such a forceful advocate for plain language in all government agency communications because we do a very poor job of communicating with taxpayers and the American public on critical issues that are affecting their lives in language they can understand, and that is why I fought to get plain-language requirements in the health care bill we just passed. That is why we need to continue focusing on that when we discuss transparency because giving consumers information means nothing if it is in a language that is too complex or arcane for them to understand, and that is why I am very, very proud of the work that has been done in these bills and I look forward to the testimony of our witnesses as we work together to provide a much more efficient health care delivery system that engages patients in their care decisions, and I yield back.

Mr. PALLONE. Thank you.

Next is the gentleman from Texas, Mr. Burgess.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman, and I appreciate also that we are having this important legislative hearing. I welcome you, Dr. Kagen, our colleague. Welcome to Dr. Herzlinger, who is no stranger to this committee and we are glad you are back.

The fact that we have advanced to the point that we are looking at specific bills and that we already have a consensus from both

sides of the dais that we need to do more in the realm of health care transparency is important. A patient should be able to know what they are paying and how much they will pay out of pocket, and on this, really there is no disagreement.

Mr. Chairman, I have been working on this issue ever since I was summoned into the office of former Speaker Danny Hastert and he charged me with developing legislation on the issue because of, then, our mutual support for the growing health savings account market, and in fact, I went back into the archives and dug up an op-ed from May of 2005 that I wrote, but nevertheless, in it I quoted Professor Uwe Reinhardt and in quoting Professor Reinhardt to move from the present chaotic pricing system toward a more streamlined system could support genuinely consumer-directed health care will be an awesome challenge, yet without major changes in the present chaos, forcing sick and anxious people to shop around blindfolded for cost-effective care mocks the very idea of consumer-directed care.

Mr. Chairman, here is the simple truth. We can't expect patients to be good consumers if they can't know the cost of the services from which they are choosing, and it is important again to stress, this has always been a bipartisan effort and I certainly appreciate the efforts of Representative Green in working on this issue over the years. We could start by looking at transparency provisions within the health reform bill, and I think we can agree as we are holding this hearing that those provisions while present are not substantial enough. I believe that everyone should have access to reliable information.

The Patients' Right to Know Act, the result of countless hours of staff negotiation between Mr. Barton, Mr. Green, Mr. Stupak, is a comprehensive measure that provides specific information to patients in regard to hospitals, ambulatory surgery centers and health plans. While some of the provisions of this measure were adopted under the reform bill, I think it once again speaks to the unanimous support of increased transparency on this committee that we were able to add a similar provision that passed unanimously to H.R. 3200 when it was presented in committee.

I do want to spend a moment on H.R. 2249, the Health Care Price Transparency Promotion Act of 2009, which was the result of work on this issue with Mr. Green and has been largely incorporated into H.R. 4803. When I engaged in this issue, I realized that many States had already enacted some and others needed to be pushed along the way and others needed to improve what they were doing. That is why this bill sets a reasonable federal floor but defers to the States to figure out what works best for them, and I am pleased that I had the support of the American Hospital Association on this effort, and I would ask unanimous consent to insert their recommendation letter into the record.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Without objection, so ordered.

Mr. BURGESS. With all the talk of transparency in this Administration, this committee ought to pay not just lip service with this hearing but promptly move legislation that will help make the information on health care cost, price and quality more transparent and thereby empowering the consumer.

I thank the chairman for the consideration. I will yield back the balance of my time.

[The prepared statement of Mr. Burgess follows:]

Health Care Transparency

Rep. Michael C. Burgess, M.D. (Texas-26)

American patients are fortunate—they have access to the greatest health care system in the world. Unfortunately for many, the cost to access that care can be prohibitively high. It is ironic that in the world's largest free-market economy, government control and a lack of true market forces have led to diminished sophistication among medical consumers and runaway health care costs. Uwe Reinhardt, a professor of political economy at Princeton University frames the problem by stating, "To move from the present, chaotic pricing system toward a more streamlined system that could support genuinely consumer-directed health care will be an awesome challenge. Yet without major changes in the present chaos, forcing sick and anxious people to shop around blindfolded for cost-effective care mocks the very idea of consumer directed care."

A lack of transparency has created a system where customers don't have the ability to hold providers and payers accountable. We have reached a point where even doctors and nurses and other providers have difficulty in being cost conscious because nobody really knows what anything costs anymore. In a system like this, double digit cost increases are a given from year to year, making health care coverage unattainable to millions of Americans.

A more transparent pricing system would help give providers and patients more control over their health care dollar, but there are great incentives for providers to keep consumers blindfolded. For instance, every year hospitals normally raise their list prices for services. Because hospitals can increase their net revenue by raising their list prices (because of a mix of third party private payers and public payers ultimately pay the bill), the incentive is to increase their list prices. But hospitals also negotiate discounted payments for patients covered by certain health plans, and these discounted amounts are not always available to individuals that may be interested in self-pay. Additional breakdowns of hospital operating costs and how that impacts billing could be essential information to a consumer as they try to select the lowest cost provider. Since this

information is obscured, the consumer can exert no pressure on a hospital to implement a rational pricing structure.

What happens when pricing information is available to consumers? The results can be dramatic. When the Medicare Prescription Discount Drug Card was introduced in 2004, seniors could log-on to Medicare.gov and see the cost comparison of what the drugs cost at area pharmacies. Seniors could determine whether it would be cheaper to get the drug at pharmacy A or pharmacy B. And then the market reacted. Pharmacies and other organizations that sponsored different discount cards began to increase the discounts on some drugs when their competitor's information was available to consumers. This is how the system should work every day.

Even some health plans are getting into the transparency game. Aetna health plan has initiated a pilot project in Cincinnati, Ohio that gives enrollees information on what doctors charge and gives enrollees the ability to take action before services are performed. This type of information is vital to hold providers and plans accountable for what they charge and what the patient pays.

Giving new consumer based coverage options, like Health Savings Accounts, the opportunity to plug into a fully transparent system would transform the American health care system in a radical manner, improving care for all Americans rich and poor. Patients with portable health care dollars that can be paid at point of service are extremely attractive to most health care providers who normally have to wait for an insurance company to process the claim and remit payment months after the service has been rendered. To attract the business of these patients, providers could list their charges, competing for business on price and quality. With nearly 3 million enrolled in HSAs to date and the number growing, health care providers and hospitals would be wise to allow transparency to pervade the system to ride the coming consumer wave.

Congress can play a role in leveling the playing field in favor of the health care consumer. HSAs should be supported and made more attractive to consumers by

increasing their portability and maximizing the tax benefits of these accounts. Congress has already established several quality reporting programs that are available to the public – the same should go for medical costs. Congress should take the lead in developing a collaborative approach with all provider stakeholders to make the costs more transparent to consumers. Yesterday, the House Energy and Commerce Committee took a positive first step in this dialogue by holding a hearing on how we can improve the quality of information available to health care consumers. The Greek dramatist Sophocles said that, "wisdom outweighs any wealth." The American health care system needs a healthy dose of wisdom that consumers can deliver given the chance.

Mr. PALLONE. Thank you, Mr. Burgess.
Next is the gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Thank you, Chairman Pallone, for convening this very important hearing. It is very important to consumers and families. We need all the help we can get to unravel this great mystery in health care costs and charges.

Health care costs and charges and bills are so confusing and so unclear that if you are a large business and you have the wherewithal to have a self-funded insurance plan, you are hiring consultants to go out and decipher what charges really cost and negotiate those costs with the providers. Unfortunately, the average American family, they simply don't have the benefit of being able to hire a consultant to help sort it out for them and hire and negotiate charges. Sometimes there is no rhyme or reason to what consumers pay for their health care. Ten different providers in one area may charge 10 different amounts for the same services but who can really find that out anyway, and it is not married to any quality measures, like it should be.

So it is important that we work to find a solid method to empower consumers to take control of what they pay for their health care by providing them with real numbers about what health services truly cost. Consumers and families should understand the what and the why for their health care bills and be able to determine when they are being charged too much or more than the actual cost of services. A truly transparent health care system should also offer a full understanding to patients and families about the cost of care with adequate time in advance for patients and health plan enrollees to assess their options and make decisions on what is in their best interest. Families should not be put in a position where they have received a service and are later stuck paying a bill that is unaffordable, too high, simply because they were not provided with clear cost options in advance. Slapping consumers with huge bills as they leave the doctor's office or hospital or any health care provider after procedures should not happen. Most patients pay what they are told to pay because they need the care. They are not equipped with the needed tools to make certain choices and most of the time those tools simply aren't available.

So let us work together and let us find a way to unravel this great mystery surrounding health care costs and charges for consumers and families. I think we will get there because we have the benefit of great leadership from Dr. Kagen, my good friend from Wisconsin, Congressman Gene Green from Texas and other colleagues on this committee. So I am hopeful that it is going to take a lot of work and we are all in this together.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, medical care in this country often falls into two categories. First, emergent care, those medical incidents arising out of emergency does not provide much opportunity or incentive for a patient to act as a traditional consumer. Patients with catastrophic conditions or events do not have an opportunity to shop around for medical services as the severity of the issue prevents that. Every patient is susceptible to these types of incidents for which health insurance is a great investment and one that should be available to all Americans.

Non-emergent care really is what we are talking about here. Non-emergent care, on the other hand, does allow opportunities and time for patients to act as traditional consumers in a manner that positively impacts the quality and of course the cost of a patient's health care. In non-emergency settings, patients should have the ability to be customers and to shop for health care services that they want and need just as they would any other consumer product. This level of interaction between patients and providers where the patient can access information on available treatments and discuss them with their medical provider can in many instances create better outcomes, more-effective treatments, and yes, lower cost health care.

So fostering this type of consumerism need not be a partisan issue. In fact, we have Democrat and Republican bills that we are going to discuss today. If given the right tools and information, patients can have the freedom to exercise choices within our health care system that do ensure quality, increased access and allow patients to spend health care dollars wisely, traits that can benefit their pocketbooks while containing national health care expenditures overall.

Health savings accounts alone do not define consumerism. They are invaluable tools for patients but insurance products are merely a means to an end. It is the ability to shop supported by the necessary information to make informed choices that is the essence of consumerism and something that our health care system should continue to support, and I certainly do. However, the benefits of informed providers do not end with the shopping for health care services. Many studies support the fact that an informed patient is more likely to engage his or her provider and an engaged provider is better able to provide a quality diagnosis that results in fewer complications and a better outcome for their patients.

With these thoughts in mind, I look forward to our witnesses today. I would like to personally welcome my friend and fellow physician, Member of Congress, Dr. Steve Kagen, on the first panel, Steve from the 8th district of Wisconsin. Steve, I look forward to your testimony as I do of the other witnesses. In the interest of full disclosure, I want to tell you that I am a cosponsor of the Barton bill, but I have looked very carefully at your bill. I am looking forward to your testimony. I think there are opportunities to work in a bipartisan way, and hopefully we can get to that point.

Mr. Chairman, I yield back.

Mr. PALLONE. Thank you, Mr. Gingrey.

Next is the gentlewoman from the Virgin Islands, Mrs. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you for holding this hearing. I also want to thank Chairman Barton and our colleagues, Drs. Kagen and Burgess, for their legislative efforts to bolster transparency in the health care delivery system and all of the other witnesses today.

It is undeniable that far greater transparency in the health care system could improve quality and save costs. Studies show that ensuring widespread access to reliable and valid data about the costs and quality differentials of the same services and treatments offered by different providers and entities would really inspire positive changes in those providers and entities that are lagging behind in quality or are charging more for services, and those changes are definitely needed.

Of course, transparency would also arm consumers with the information necessary to make informed decisions, which would be extremely important to those more than 32 million Americans who will be leaving the ranks of the uninsured for the first time and for the first time be faced with those choices and options about their health care.

In terms of health equity, I think that improving transparency could also play an important role in our ongoing efforts to achieve equality because it would afford better measures to monitor and reduce the costs and quality differentials that not only occur between providers and facilities but between consumers of different races and ethnicities and particularly geographic differences where we know in poor communities in those poor zip codes costs are different.

It is clear to me that all of the stakeholders in the health care system pay a price for the current absence of transparency and so as a physician, as a health care consumer, as a member of this committee, I hope that we can work together building upon the Patient Protection and Affordability Care and Reconciliation Act to bring about meaningful transparency consistently across the entire health care system, and of course including in the territories in a manner that doesn't overburden providers and health care entities, especially those practicing in inner cities and rural communities.

So I thank you. I welcome you, Dr. Kagen, and look forward to your testimony and the discussion this morning.

Mr. PALLONE. Thank you, Ms. Christensen—well, actually, we have all these doctors here today, Dr. Christensen, Dr. Burgess, Dr. Gingrey, Dr. Kagen, Dr. Murphy who is next.

I recognize the gentleman from Pennsylvania, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY OF PENNSYLVANIA. Thank you, Mr. Chairman. Good to see you today, Doctor.

You know, I was recently shopping for a used car and I realized I could get a vehicle history report that told me about if the car has been in an accident, been stolen, had flood damage. I could find out if I am going to pay a fair price for it. I can go to Consumer Reports if I am buying a new car and get all kinds of information. That information is just a click away. I can readily get information on cost and quality so I can make value comparisons. But I can't do that with medicine. Oh, I could look up some reports on doctors, get information of where they went to medical school and other aspects about that, but when you try and track what you actually do with health care, it is a problem.

Let us say a nerve in your neck has been pinched, so you call an urgent care center that says let us do an X-ray that costs \$60 to \$160. Later you find out well, that X-ray is not going to decide if you have got a slipped disc. So someone says get an MRI. So being price sensitive, you say let me shop around for the best possible price, but no nurse or doctor is going to tell you how much it is going to cost or where to get the best MRI procedure and one that is going to get you the right information and go on to the right doctors or if they have electronic medical records that can then pass that information on. What if we are talking about some more serious like triple bypass surgery? Chances are pretty good the patient is going to next to nothing about the doctor or the facility. You can find better reviews about a blender then you can about a bypass, and you are not even going to know if you are going to get an infection in that hospital.

Many people have heard me say repeatedly that hospital-acquired infections cost \$50 billion and 100,000 lives each year but even our recently passed trillion-dollar health care bill doesn't require hospitals to have a standard public reporting method where we can find out about infection rates in hospitals, even though States that have done that have seen with hospital awareness a great decline in their infection rates.

You know, if we really do transparency, and I am all in favor of this and we need to have price and quality transparency, we would really be making some major changes in quality in health care in America. Perhaps for the first time we would be making the kind of changes that years and years ago people got from an informal method from the doctor in town but now the business has grown so big and costs have grown so much we just can't get that anymore. We absolutely have to have price transparency but let me add with that, price transparency means nothing without quality transparency, and we need to make sure those are joined together.

So the next people go to Consumers Reports magazine or go online and compare all those little items they can get from the latest screwdriver to the latest larger purchase price item, hopefully some day we can look at that and say wouldn't it be great to get that kind of information that is going to save the lives of my family, myself and really work to drive down health care costs by driving up quality and price consciousness.

With that in mind, I look forward to hearing some of the insights and testimony as you are before this panel of all these health care experts as well, and thank you, Mr. Chairman, for holding this hearing.

Mr. PALLONE. Thank you.

Ms. Sutton, would you like to make an opening statement?

Ms. SUTTON. Thank you, Mr. Chairman. I would.

Mr. PALLONE. You are recognized for an opening statement.

**OPENING STATEMENT OF HON. BETTY SUTTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. SUTTON. Thank you. I appreciate you holding this hearing today.

Transparency is an issue that I care about deeply. In general, transparency is a critical factor in decision making. Knowing as much information as you can is important, whether you are deciding where to move or what car to buy. There is not an industry more opaque and less transparent than the health care industry. It is not transparent from a number of perspectives from the price of health insurance policies to the cost of procedures. Most doctors and hospitals are hard pressed to come up with an answer when patients ask how much something costs, and the people who have the hardest time in the system are the people who are their own advocates, patients, patients with no insurance or high-deductible health insurance plans and small businesses who are attempting to purchase health insurance for their employees.

While transparency in health care pricing is an admirable goal, it is not the panacea to our health care problems because if you can't afford health insurance and health care, you can't afford it no matter how transparent the price might be, and unlike other markets, the health care market does not always respond to transparency. No one who is in a car accident is asking the ambulance driver what the cost of ER services is in one hospital as compared to another hospital, but there are some instances where the health care can respond to price transparency in determining which insurance company provides the most medical care per dollar spent or where a patient is looking for a health care provider for a non-emergency procedure like a colonoscopy.

I look forward to hearing about what we can do to enhance the transparency provisions that are already in health care reform and to ensure that Americans are given every opportunity to have quality and affordable health care.

I thank you, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

I believe that concludes our opening statements so we will now move to our first panel, our only witness, and that is the Hon. Steve Kagen, the gentleman from Wisconsin and the sponsor of H.R. 4700, the first bill on our agenda.

I just want to thank him. He, as you know, is a physician. He has been very aggressive in pushing this transparency issue, both with me and other members, to his credit. We all think it is a very important issue but I think that without his pushing us, we wouldn't probably be here today. So thank you, Congressman Kagen, and you are recognized.

STATEMENT OF HON. STEVE KAGEN, MEMBER OF CONGRESS

Mr. KAGEN. Thank you, Mr. Chairman. I couldn't agree with you more about your opening remarks about why we are here.

Thank you for holding this meeting. Thank you to Ranking Member Shimkus and Chairman Emeritus Dingell, who could not be here this morning. Thank you to all members of this subcommittee for joining us in this very constructive conversation about transforming our health care system and creating a very competitive medical marketplace.

I am Steve Kagen. I have lived in northeast Wisconsin for my entire life, and before becoming a Member of Congress I practiced in a privately owned and operated medical clinic throughout northeast Wisconsin. I have also served in VA hospitals for 3 decades, so I understand both a government-run situation and a private system.

Today you are going to hear testimony from a number of expert witnesses on the importance of establishing a transparent medical marketplace to help to guarantee that the highest quality care becomes available to everyone at the lowest possible price. We are very fortunate in Wisconsin to be leaders in health care, making progress and guaranteeing that there is quality measurement, not just within the hospital institution itself but also on the Internet, as you will hear from the CEO of ThedaCare Center for Health Care Value, Walt Rugland.

As every member of this subcommittee already knows, health care in America is upside down. When someone with no insurance gets sick and goes to the hospital, the hospital gives you the big bill, but if someone else goes to the hospital and has insurance, they get a discount. Health care is upside down. This takes place each and every day in my district and every district of the members of this committee and the members of everyone in the House.

While the passage of our Nation's health care security law earlier this year will help to guarantee that no citizen will lose their home or go broke just because they become sick, it needs to take another step and to guarantee that everyone can see the price of everything they are buying at all times, most especially beforehand. Competition is a good thing. Indeed, it is an essential element of capitalism, and when there is a level playing field, competition will drive quality up and prices down.

Everyone knows that the listed prices for medical services are meaningless for the real price is being hidden. Therefore, prices our constituents pay for insurance coverage, for prescription drugs and for hospital and doctor bills are "whatever they can get."

Take, for example, the recent article that appeared in the L.A. Times on April 24, 2010, and you can see this slide before you. I will quote from that article. "Tom Taylor learned a lesson about health care finances when he had both his knees replaced a couple months apart at separate hospitals in northern California. The tab for the first hospital was \$95,000 but the second cost \$55,000. The same doctor performed identical surgeries on both knees, and Taylor says he can't detect any differences between the two." Quotes Mr. Taylor, "Nobody knows what it costs. There is a complete lack of transparency in our health care system."

Well, here in my hand I have a prescription, and everybody understands today that if we all have the same prescription for the same medication and go to a pharmacy and stand in line, we may all pay different prices for the same prescription our doctor has or-

dered. This has got to come to an end. We have to have open disclosure of all prices all throughout health care.

Now, some people will make the argument that average prices for medical products and services should be available publicly but who among us wants to receive average care and who among us wants to go to the store and get the average change when you pay for your restaurant bill?

Some will argue that showing everyone all the prices is too complex and there are thousands of prices at any given hospital, but today's technology allows us all of us to go online on the Internet and search for items to purchase and find exactly what we want and buy it within milliseconds. Some will argue that a hospital cannot know in advance what to charge you for taking out your gallbladder. Well, you only have one gallbladder and there is only reason to take it out: it is bad. So how much does one bad gallbladder cost at everybody's hospital?

If you want to do something really complicated, do what I did the other way. Go into Subway and order a sandwich. There are two to the 23rd power combinations of choices you have to make and then you get to the cash register, and what do they say? That is \$5 for a footlong sandwich. If the owners of Subway can figure out how to lump things together and make a living, maybe we ought to have that same lumping idea in health care. In restaurants and in hospitals, lumping makes more sense than splitting.

We have made great progress together this year and as I heard from all of you in your opening statements, you are in a very cooperative and bipartisan manner right now and I appreciate that. But we have to take the next step together.

When enacted, The Transparency In All Health Care Pricing Act of 2010 will guarantee that any individual or business entity that offers health care products or services for sale to the public must at all times openly disclose all of their prices, including on the Internet, and doing so will help to establish a very competitive medical marketplace, allow families to find the essential information necessary to make their health care decisions based upon the quality, the price and the services being available, not only in their hometown area but across the Nation.

We all believe in transparency and so does President Obama when he said, "Transparency promotes accountability." Without transparency in all health care pricing, there will continue to be opportunities for fraud and market manipulation, much like occurred on Wall Street in the financial meltdown.

We can fix our health care system and improve on what we already have done by working together, so let us create a competitive medical marketplace where all of the prices we pay are always openly disclosed, including on the Internet.

Thank you, Mr. Chairman, for holding this important hearing, and I very much look forward to the testimony of Walt Rugland, who has not only devised a way of taking care of patients in a more economical fashion by lowering the overhead at his hospital but has also increased the quality with zero medication errors in an entire year. It is not a theoretical process; they have actually done it in Appleton, Wisconsin.

I thank you and yield back the additional minute I took from you.

[The prepared statement of Dr. Kagen follows:]

WRITTEN TESTIMONY OF HONORABLE STEVE KAGEN, M.D., WI

THE HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

MAY 6, 2010

TRANSPARENCY IN HEALTH CARE PRICING

PRESIDING MEMBERS:

HONORABLE CHAIRMAN FRANK PALONE, N.J.

HONORABLE RANKING MEMBER JOHN SHIMKUS, IL

HONORABLE CHAIRMAN EMERITUS JOHN DINGELL, MI

The Transparency In All Health Care Pricing Act of 2010 (H.R. 4700)

Thank you Chairman Pallone, Ranking Member Shimkus, Chairman Emeritus Dingell, and all Members of the Subcommittee on Health for holding today's important hearing on transparency in America's health care delivery system.

My name is Dr. Steve Kagen. I have lived in Northeast Wisconsin my entire life and, before becoming a Member of Congress, I practiced medicine in a privately owned clinic during three decades as an Allergy, Asthma and Immunology Specialist, having also served our military veterans in multiple VA hospitals.

Today, you will hear testimony from a number of expert witnesses on the importance of establishing a transparent medical marketplace to help guarantee the highest quality of care at the lowest possible prices.

In Northeast Wisconsin, we are extremely fortunate to have the highest quality care in the nation. We have a number of excellent health care entities, including Affinity, Bellin-NEWHVN, Prevea, ThedaCare and Aurora-BayCare health care systems – all working to provide integrated models of coordinated continuing care. And this morning, you will hear testimony from one of the nation's thought leaders in health care reform from my hometown of Appleton, Wisconsin, Walt Rugland, the CEO of the ThedaCare Center for Health Care Value.

As every Member of this Subcommittee already knows, health care in America is upside down. When someone with no insurance gets sick and goes to the hospital, the hospital gives them the Big Bill, but if someone else who has insurance goes to the hospital, they receive a discount.

This takes place each and every day in your congressional district and mine, primarily because there is no price transparency in our health care marketplace.

While the passage of our nation's new health security law earlier this year will help guarantee that no citizen will lose their home or go broke just because they get sick or have an accident, it did not create a transparent medical marketplace to foster competition between caregivers, pharmaceutical manufacturers and health insurers. Competition is a good thing, indeed, it is an essential element of capitalism, and when there is a level playing field, competition drives quality up and prices down.

Everyone knows that the listed prices for medical services are meaningless, for the real price is being hidden; therefore, prices our constituents pay for insurance coverage, for prescription drugs, and for hospital and doctor bills are "whatever they can get."

Take for example the recent case of Mr. Tom Taylor whose story appeared in the L.A. Times on April 24, 2010, which reads: (slide 1)

Tom Taylor learned a lesson about healthcare finances when he had both his knees replaced a couple of months apart at separate hospitals in Northern California.

The tab at the first hospital was \$95,000, but the second cost \$55,000.

The same doctor performed identical surgeries on both knees, and Taylor says he can't detect any differences between the two. □ □

"Nobody knows what it costs," said Taylor, 53, a former health insurance sales executive.

"There is a complete lack of transparency in the healthcare system." □

Here in my hand is a prescription bottle with 30 pills in it. How much does it cost? The price accepted as payment in full depends upon who is paying for it, only because prices are not being openly disclosed to the public.

There is no reason patients should be prevented from knowing the price of a pill before they buy it – and knowing what the person in line in front of them is paying for the same prescription. If all of us in this room have the same prescription, and we are standing in line at a given pharmacy, is there any good reason that we are all paying a different price? Only in health care is the price non-transparent.

Some will make the argument that average prices for medical products and services should be revealed publicly. But who among us wants to receive average care or receive the average change when we buy something?

Some will argue that showing everyone all of the prices is too complex, for there are tens of thousands of prices at any given hospital. But today's technology allows all of us to go online on the Internet and search for items to purchase and find exactly what we want to buy within milliseconds.

Some will argue that a hospital cannot know in advance what to charge you for taking out your bad gall bladder, because there may be complications, and that no two patients are exactly the same. This may be true, but if they want to do something really complicated they should go to Sub-Way and order a sandwich. There are 2 to the 23rd power combinations of choices to make in placing your order, but a foot-long sandwich costs you \$5 - no matter what you decide to put into it. If the owners of Sub-Way can figure out how to make money by "lumping" their prices, so can our nation's hospitals.

In restaurants and hospitals, lumping makes more sense than splitting.

We have made a great deal of progress together improving on what we already have in our health care system, and now it is time to finally allow consumers to see all of the real prices for health care.

When enacted, The Transparency In All Health Care Pricing Act of 2010 will guarantee that any individual or business entity offering medical products or services for sale to the public will at all times openly disclose all of their prices, including on the Internet.

Doing so will help to establish a very competitive medical marketplace, allowing families to find the essential information necessary to make their health care decisions based upon the quality, the price and the service of available caregivers within their hometown area and even across the nation.

We all believe in transparency and so does President Obama, as he said, "Transparency promotes accountability."

Without transparency in all health care pricing, there will continue to be opportunities for fraud and price manipulation – much like occurred on Wall Street. We have all experienced economic damages caused by opaque and non-transparent financial markets in the greatest economic recession of our time, and we must, therefore, prevent such occurrences from taking place in health care.

We can fix our health care system by working together.

Let's create a competitive medical marketplace, where all of the prices we pay are always openly disclosed, including on the Internet. Let's enact H.R. 4700, The Transparency in All Health Care Pricing Act of 2010.

Thank you again Mr. Chairman for holding today's hearing.

Steve Kagen, M.D.

Member of Congress

Wisconsin – District 8

Mr. PALLONE. Thank you, Congressman Kagen.

You know, our policy is not to ask questions of Members. Even though we love you dearly, we are not going to ask you any questions. So thank you very much and thank you for also bringing some of the witnesses today and talking about the witnesses as well.

So we are going to move to the second panel. Would the members of the second panel please come forward? We will put the names up so you know where to sit.

Mr. BRALEY. Mr. Chairman?

Mr. PALLONE. Who seeks recognition? Oh, Mr. Braley, yes.

Mr. BRALEY. I just want to point out there is another hearing going on downstairs and some of us will be moving in and out from time to time.

Mr. PALLONE. OK, sure. I sure also point out that Ms. Blackburn wanted to introduce Mr. Holden but she is back in Tennessee because of the floods, from what I understand, so that is why she is not able to be with us today.

Thank you for being here. I want to welcome the panel. As you know, the process is that we hear 5-minute opening statements from each of you. I hope you can stick to that. And those statements will be made part of the hearing record and then each witness may in the discretion of the committee submit additional brief or pertinent statements in writing for inclusion in the record at a later time.

So let introduce each of you from my left to right. First is Mr. Steven J. Summer, who is president and chief executive officer of the Colorado Hospital Association on behalf of the American Hospital Association. Second is Dr. Regina Herzlinger, who is professor of business administration at Harvard Business School. And then we have Mike Cowie, who is a partner in Howrey, LLP. And then I have Walter Rugland, who is the chairman of the board for ThedaCare, Incorporated, and Terry Gardiner, who is the national policy director for the Small Business Majority, and finally is Christopher Holden, who is president and chief executive officer of AmSurg.

And we will start with Mr. Summer who is recognized, and move that over. You probably have to put it pretty close to you and turn the green button on. Otherwise we won't hear you.

STATEMENTS OF STEVEN J. SUMMER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COLORADO HOSPITAL ASSOCIATION, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; REGINA HERZLINGER, PH.D., PROFESSOR OF BUSINESS ADMINISTRATION, HARVARD BUSINESS SCHOOL; MICHAEL COWIE, PARTNER, HOWREY, LLP; WALTER RUGLAND, CHAIRMAN OF THE BOARD, THEDACARE, INC.; TERRY GARDINER, NATIONAL POLICY DIRECTOR, SMALL BUSINESS MAJORITY; AND CHRISTOPHER HOLDEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMSURG

STATEMENT OF STEVEN J. SUMMER

Mr. SUMMER. Good morning, Mr. Chairman, and thank you and thank you to Ranking Member Shimkus. I am Steven Summer,

president and CEO of the Colorado Hospital Association. I am here today on behalf of the American Hospital Association and its 5,000 member hospitals. We appreciate the opportunity to share with you and your colleagues information about the hospital field's efforts on price transparency.

Patients and their families deserve information about the price of their hospital care, and the AHA and its members are committed to providing it. Sharing meaningful information, however, is challenging, as we have heard in the statements earlier, due to the unique nature of hospital care. An operation for one patient may be relatively simple, but for another, it could be more complicated, making it very difficult to provide meaningful information up front. Moreover, hospital prices do not often reflect important information from other key players such as physicians or how much of a care is paid for by the patient's insurance.

With the passage of health reform hospitals will report annually and make public a list of hospital charges for items and services. Currently, CMS posts information on the Hospital Compare Web site on what Medicare pays for 35 common procedures. But more can and should be done to share health care information with the public, including, but not limited to, hospital pricing information.

The path to price transparency has four parts. First, with respect to States, working with State hospital associations like the Colorado Hospital Association should expand existing efforts to make hospital charge information available to consumers. Forty-one States including Colorado already have mandatory or voluntary hospital price information reporting activities already in place. These efforts vary from making hospital charge masters available to the public to making public pricing information on frequent hospital services to making information available on all inpatient services.

Health insurers should also make available in advance of medical visits information about enrollees' expected out-of-pocket costs. This information is generally provided by a patient's insurance company after care through what is known as an explanation of benefits, or an EOB. But consumers need insurers to provide real-time information through either the phone or through the web page that that is the EOB that they can get from their insurance company what the insurance company will pay and what their copayments will be.

We also need more research to help us better understand what type of pricing consumers actually want and would find useful in their decision making. We all know the kinds of information consumers seek about quality of health care but we know less about what they might want about pricing information.

For uninsured individuals, information is often provided directly by the hospital. The hospital in turn in those cases can determine if the patient qualifies for certain kinds of public insurance programs whether they would qualify for free or reduced care that is provided by the hospital or other forms of financial assistance which is available.

As part of the health care reform bill, tax-exempt hospitals will be required to adopt and implement and widely publicize their financial assistance policies. This is consistent with previous policies

adopted by the American Hospital Association and the Colorado Hospital Association.

And lastly, we firmly agree that everyone needs to have access to consumer-friendly pricing language, common terms, definitions and explanations which will help consumers better understand pricing information. The need of our patients to understand the billing process is paramount.

I would also like to tell you a little bit about what is going on in Colorado. We published starting over 20 years ago what we call the hospital charges and average length of stay report. This annual publication provides information that allows us to compare charges and lengths of stay on 35 of the most common medical treatments and surgical procedures provided in Colorado hospitals. The publication includes comparisons that take into account any complications the patients may have and the severity of their illness. It lists average charge and the average length of stay and breaks that into four categories of severity. The report also presents statistically standardized ranges of high and low numbers of both charges and length of stay. When a patient is given a procedure in the hospital, there is a 95 percent probability that they will fall at the range within the information of the length of stay and the charges in this report. We make this report available on the Web and anybody can download it. We also provide it to libraries throughout the State of Colorado.

In 2007, we took a step forward. With the health department we began to add a Web site that expands pricing information to allow patients and families to compare the quality and safety of their experiences in Colorado hospitals. The information shows the outcome of patient care presented for each hospital for the past 3 years. Hospitals are identified as being statistically better, the same or worse outcomes as compared to other hospitals in the State, and right now the Colorado legislature is considering what we call an all-payer bill, which will require health plans to provide more information to be collected by insurance companies.

The American Hospital Association supports the Health Care Price Transparency Promotion Act introduced by Representatives Burgess and Green and we agree that consumers do need accurate information when making health care decisions. We appreciate the opportunity to be here today, Mr. Chairman, and the American Hospital Association stands ready to work with Congress to find innovative ways to build efforts occurring at the State level and share appropriate information with consumers. Thank you very much.

[The prepared statement of Mr. Summer follows:]



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**Testimony
of the
American Hospital Association
before the
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health**

**“H.R. 4700, the Transparency in All Health Care Pricing Act of 2010;
H.R. 2249, the Health Care Price Transparency Promotion Act of 2009; and
H.R. 4803, the Patients’ Right to Know Act”**

May 6, 2010

Good morning, Mr. Chairman. I am Steven J. Summer, president and chief executive officer of the Colorado Hospital Association (CHA). I am here today to testify on behalf of the American Hospital Association (AHA) and its nearly 5,000 member hospitals, health systems and other health care organizations, and its nearly 40,000 individual members. I appreciate this opportunity to share with you and your colleagues information about the hospital field’s support for price transparency in the health care field.

The AHA believes that consumers deserve helpful information about the price of their hospital care, and is committed to providing it. Sharing meaningful information, however, is more challenging because hospital care is unique. For example, a gall bladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful “up front” pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not reflect important information from other key players, such as the price of physician care while in the hospital or how much of the cost a patient’s insurance company may cover.



With the passage of the *Patient Protection and Affordable Care Act* (PPACA), hospitals will report annually and make public a list of hospital charges for items and services, including Medicare-Severity Diagnosis-Related Groups (MS-DRGs). The Secretary of the Department of Health and Human Services (HHS) will establish guidelines for public reporting beginning this year. Currently, the Centers for Medicare & Medicaid Services posts information on the *Hospital Compare* website on what Medicare pays for 35 procedures. These data show the range of payments by county and the number of cases treated at each hospital for a variety of treatments, including heart operations, implantation of cardiac defibrillators, hip and knee replacements, and kidney and urinary tract operations, among other procedures.

But more can – and should – be done to share health care information with the public, including, but not limited to, hospital pricing information.

BACKGROUND

Four years ago, the AHA Board of Trustees approved a policy regarding hospital pricing transparency. That policy calls for information to be presented in a way that:

- is easy to access, understand and use;
- creates common definitions and language describing hospital pricing information for consumers;
- explains how and why the price of patient care can vary;
- encourages patients to include price information as just one factor to consider when making decisions about hospitals and health plans; and
- directs patients to more information about financial assistance with their hospital care.

The AHA believes that the path to price transparency has four parts. The first is that states, working with their state hospital associations, expand existing efforts to make hospital charge information available to consumers. Many states already have mandatory or voluntary hospital price information reporting activities in place. An AHA survey found that 34 states require hospitals to report information on hospital charges or payment rates and make that data available to the public; an additional seven states, including Colorado, have voluntary efforts. These state efforts vary, from making individual hospitals' lists of master charges available to the public, to making public pricing information on frequent hospital services, to making information on all inpatient services publicly available.

Second, states, working with health insurers, should make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs. For individuals with health insurance, this information is generally provided after care via an "explanation of benefits," or EOB. Consumers need insurers to provide real-time information – either via the phone or an on-

line EOB – that tells them what their insurance company will pay and what their individual co-payment will be. With insurance coverage expected to be expanded to 95 percent of legal U.S. residents under the PPACA, most individuals will need to access such information.

Third, more research is needed to better understand what type of pricing information consumers want and would find useful in their health care decision-making. Through research we have learned much about what kind of information consumers are seeking regarding the quality of health care, but we know less about what they may want to know about pricing information. Consumers need different types of pricing information depending on whether and how they are insured. For example, a patient with traditional insurance that typically covers hospital services may want to know what the out-of-pocket costs would be for care at one hospital compared to another. Those with high-deductible health plans or health savings accounts also would have more interest in what their insurers require as out-of-pocket costs, as patients with high-deductible plans are responsible for the out-of-pocket costs of their initial care, up to their personal deductible. But people with HMO coverage, who have agreed to use physicians and hospitals participating in their health insurance network, likely would have less need for specific price information.

For uninsured individuals of limited means, information should be provided directly by the hospital; the hospital, in turn, can determine whether a patient qualifies for state insurance programs, free or reduced cost care provided by the hospital, or other financial assistance. As part of the PPACA, tax-exempt hospitals will be required to adopt, implement and widely publicize (within the community the hospital serves) a written financial assistance policy. This new federal policy is consistent with previous AHA policies and field recommendations and includes specifications such as: (1) eligibility criteria for financial assistance and whether the assistance includes free or discounted care; (2) the basis for calculating amounts patients are charged; (3) how to apply for financial assistance; and (4) any actions that may be taken for non-payment if the organization does not have a separate billing and collections policy. In addition, the new law underscores field practice and existing regulations by emphasizing that each hospital must have a written policy to provide emergency medical care, regardless of whether or not the patient qualifies for financial assistance. Again, consistent with AHA policy and recommendations, a hospital is permitted to bill patients who qualify for financial assistance no more than the amounts generally billed to individuals who have insurance coverage for such care.

Finally, we all need to agree on consumer-friendly pricing “language” – common terms, definitions and explanations to help consumers better understand the information provided.

THE COLORADO EXPERIENCE

As mentioned above, Colorado is one of the seven states with a voluntary reporting program. The Colorado Hospital Association began publishing the Hospital Charges and Average Length of Stay Report in 1988. This annual publication provides patients, their families, researchers, policy makers, and purchasers of health care such as businesses and insurance companies with information to compare charges and lengths of stay for the 35 most common inpatient medical conditions and surgical procedures performed in Colorado hospitals.

The publication has evolved over the years to include comparisons that take into account any complicating illnesses patients may have, and the general severity of the patient's illness. It not only provides the average charge and average length of stay for each condition or procedure, but also includes the average charges and average lengths of stay for each of four categories describing how sick the patient is.

In addition to the average charge and average length of stay, the report presents a statistically standardized range of low and high numbers for the charges and length of stay. These ranges represent what the patient is likely to experience as a result of his or her care. When a patient is treated in a hospital for a given procedure or condition, there is a 95 percent probability that his or her charges and length of stay will fall within these respective ranges.

Other useful information, such as the number of patients each hospital treats for each of the conditions and procedures, easy to understand descriptions of the conditions and procedures, explanations of hospital charges and lengths of stay, what they represent, what their limitations are and general demographic information on each hospital, also is presented.

The report is made available free of charge to the general public on the CHA website and in paper format. It also is provided free of charge to public libraries. Hospitals are given a specially designed electronic data file that they load into their information systems. It includes charge and length of stay data for all the conditions and procedures treated at that hospital. This provides hospital staff the ability to give patients charge and length of stay estimates prior to a hospital visit.

In 2007, CHA and the Colorado Department of Public Health and Environment began publishing the Colorado Hospital Report Card. This interactive website expands on our pricing publication, allowing patients and their families to compare the quality and safety of care in Colorado hospitals. Information showing the outcomes of patient care is presented for each hospital for each of the past three years. Hospitals are identified as having statistically better, the same, or worse outcomes as compared to other hospitals in the state. The website is updated annually each November. In addition, last year CHA worked with the Colorado Division of Insurance to

publish a website showing both charges and payment information for 25 of the most common reasons for hospitalizations.

This year, the Colorado Legislature is considering legislation allowing more detailed information to be collected from insurance companies. Access to this information will have the potential to further enhance the reporting already available to the public. It can be used to provide estimates of the out of pocket co-payments associated with a hospital stay. CHA supports this legislation, and is looking forward to continuing its tradition of making hospital costs and quality information available to our patients and their families.

LEGISLATION UNDER CONSIDERATION BY CONGRESS

As previously mentioned, the AHA supports state efforts, like Colorado's, regarding price transparency. We also support legislation like H.R. 2249, *The Health Care Price Transparency Promotion Act of 2009*, introduced by Reps. Michael Burgess (R-TX) and Gene Green (D-TX), which would build on this existing state-based structure and also require insurers to participate in the disclosure process by providing information on estimated out-of-pocket costs for health care services. The 41 states with either statutory or voluntary requirements for hospitals to report information on hospital charges or payment rates make the information available to the public, either by posting to a hospital website, by publication in a government or hospital association report or by making the information available to consumers upon request. H.R. 2249 would expand the reporting requirements to all 50 states. The legislation also would require insurers to provide information about an enrollee's expected out-of-pocket expenses. H.R. 2249 also would require the Agency for Healthcare Research and Quality to conduct a study on the types of price information consumers want and would use in their health care decision-making.

Legislation introduced more recently, H.R. 4803, *The Patients' Right to Know Act*, also focuses on the state-based approach to collecting and disseminating hospital price information, and would expand these requirements to ambulatory surgery centers. The bill requires health plans to provide to their enrollees information on covered items and services, the claims appeal process and out-of-pocket cost-sharing, among other topics.

H.R. 4700, *The Transparency in All Health Care Pricing Act of 2010*, would require reporting of a broad range of price information from almost every entity that participates in the health care sector. This would include hospitals, physicians, nurses, pharmacies, pharmaceutical manufacturers, dentists, health insurers and any other health care-related providers that offer or furnish health care for sale to the public (and including any government-run programs such as Medicare and Medicaid) and would require them to publicly disclose all prices – all wholesale, retail, subsidized, discounted, etc. – that are charged to individual consumers. The HHS

Secretary would have the authority to investigate and fine any entities that failed to comply with the posting requirements.

CONCLUSION

Hospitals are a critical component to the fabric and future of our communities. We agree that consumers need accurate information when making health care-related decisions for themselves and their families. Providing understandable and useful information about health care costs is just one way that America's hospitals are working to improve the health of their communities.

The AHA and its members stand ready to work with lawmakers on innovative ways to build on efforts already occurring at the state level and share information that helps consumers make better and smarter choices about their health care.

Mr. PALLONE. Thank you, Mr. Summer.
Dr. Herzlinger.

STATEMENT OF REGINA HERZLINGER

Ms. HERZLINGER. Chairman Pallone, Ranking Member Shimkus, thank you so much for inviting me.

Not so long ago, a similar group was testifying about transparency. People would not understand it, it would cause price collusion, what was available through State agencies was good enough. Who were the testifiers? They were businessmen in the midst of the Great Depression aiming to persuade the U.S. Congress not to enact the transparency legislation backed by the great President Franklin Delano Roosevelt when he created the SEC. Happily, the Congress ignored them. Extensive research demonstrates that financial transparency lowers the cost of capital because investors who were more certain about performance required lower returns and enabled the investors to reward productive, socially responsible firms more than others.

We now stand at a similar moment. Transparency about the quality and cost of health insurance and medical care providers is essential not only for the 34 million who will newly shop for plans under the health reform legislation but for the rest of us too, essential but not available. Transparency could not only help people but could also control the health care costs which are now ruining a wonderful economy by revealing which insurance companies and policies provide the most medical care benefits and best outcomes per dollar, which ones offer the best doctors and hospitals and which ones hassle sick people the least. In health care, as elsewhere in the economy, the best providers are frequently the lower cost ones.

Finally, if medical care providers were required to post their prices for the uninsured, competition would likely follow. Some medical bankruptcies, one-quarter of which are incurred by the uninsured, could be avoided if uninsured people could compare the prices and quality with their medical care. Yet despite health care transparency's many benefits, we have virtually none of it. Transparency sites maintained by State governments with the notable exception of Wisconsin and some other States and private firms contain sparse, frequently outdated information.

Can transparency be obtained through voluntary efforts? Obviously not. Few health care participants have willingly offered disclosure. Instead, many stakeholders raise objections including the allegations that consumers lack interest, lack ability, that transparency's costs will exceed its benefits and that the measurement of quality is infeasible. But the Congressional Research Service has decided that the many benefits of transparency trumps its costs and although health care transparency measures are not as yet well developed, with time they will be.

The problem is not that Americans aren't interested in health care transparency, they rated it as their number one health care reform they want from the government. Nor is it that they cannot wend their way through information. Google and Consumer Reports are there to help them through it. The problem is that Americans still lack the health care transparency they need. Passage of

the legislation being discussed today will help ensure they get it.
Thank you.
[The prepared statement of Ms. Herzlinger follows:]

**The Missing Health Care Reform:
Transparency**

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May 4, 2010

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Health care transparency was surprisingly absent from the health care reforms enacted in 2010. The passage of the transparency Bills presented today will help to rectify this omission .

After all, transparency can help foster significant cost and quality improvements and improve access for the uninsured . Additionally, unlike some reform elements, the American people very much want the government to effect transparency: the number one change Americans wanted from the government in one survey "was requiring that performance ratings on hospitals and doctors be publically available."¹

Cost control—Generally, consumers get better value as transparency increases.² With health care transparency that could help them answer questions like "Which insurance companies and policies offer the most medical care benefits per dollar spent? Treat sick people the best? Offer the best doctors and hospitals? Are disliked by doctors and hospitals because of their slow and low payment practices?", consumers could reward insurers who gave them the best value, encouraging competition and innovation. The health insurance industry is surprisingly entrepreneurial:³ the firms currently dominating the high deductible insurance market were formed only nine years ago, for example.⁴

Transparency could help insurers to better control costs by constructing narrow networks of the best value doctors and hospitals. UnitedHealth estimated savings of \$37 billion from 2010-2019 from incentives to use the highest quality health care providers.⁵ Health insurers typically do not offer these narrow networks because the American people suspect that insurers favor low-cost providers, rather than high-quality ones. The availability of independent data through which enrollees could verify the quality of doctors and hospitals would alleviate such concerns.

Further, the mere act of obtaining data motivates positive changes among suppliers, a phenomenon known as "the audit effect."⁶ The US Congressional Budget Office, for example, estimated that sharing peer profile scorecards with physicians would save Medicare \$350 million from 2010-2014.⁶

Quality effects—Transparency can also spur quality improvements. For example, although researchers virtually eliminated an ICU infection in Michigan that kills up to 60,000 people annually in the U.S., their intervention has not spread rapidly, perhaps because deaths from infections are invisible.⁷ If hospitals were required to publically report valid data, infection rates would likely plummet.

Evidence suggests that hospitals respond to publicly reported data with efforts to improve patient care and their

standing in reports.⁸ Patients respond too: in New York and Western Pennsylvania they increased the market share of higher quality providers.⁹ When English patients and providers obtained information about hospital quality and waiting times, as part of a package of reform which included public performance ratings, both measures of performance improved significantly.¹⁰

Access impact—Currently, charges for the medical care of the uninsured are difficult to find and differ widely. One study found that the uninsured paid 75% more for one procedure than Medicare patients.¹¹ Public posting of charges would enable the uninsured to more readily compare competitive prices.

Yet transparency is not without risks. Some economists believe that in a concentrated market, like many in health care, transparency can lead to collusion.¹² Others may believe that some degree of price discrimination is essential for equity. Yet, a recent Congressional report which assessed all these risks concluded that transparency can help improve quality and reduce costs.¹³

We lack transparency primarily because government has not required it, failing to invest in developing robust measures, to create standards for measuring quality, and to ensure that accurate and reliable data are readily available. The available public data are limited. Hospital Compare, the Website of the U.S. Department of Health and Human Services, for example,

reports on only six medical conditions and 26 surgical procedures.¹⁴ It contains measures only of the *process* of providing medical care—did the hospital give you an antibiotic before the surgery—rather than *outcome* data—how often patients were infected in this hospital? Yet, consumers do not value such process data highly.¹⁵ In 2008, only 6% of surveyed Americans heard of Hospital Compare.¹⁶

Although more than 40 states and a number of private organizations¹⁷ provide some health care transparency, they too are not fully responsive. Moreover, they offer limited input from consumers,¹⁸ although consumers value information obtained from people like them highly.¹⁹ Further, none of the state sites compare their data to the best in class in the U.S. For example, Maryland's Johns Hopkins may provide best in class care for prostate surgery and the Massachusetts General Hospital for thoracic surgery but the users of transparency sites in each state will likely not know that.²⁰ The absence of this information also inhibits the nascent movement in inter-state medical tourism and its cost savings²¹ and quality improvements.²²

Similarly, a survey of the transparency efforts of 25 nonprofit hospital systems concluded that "none of the healthcare systems studied had information available on their Web sites that was relevant, reliable, and transparent in all .

. . . categories." Their quality transparency data earned among the lowest ratings.^{23, 24}

Government Success in Transparency

The public's desire for transparency and the failure of markets to create it warrant governmental action. The government's efficacy as a transparency agent is exemplified by the Securities and Exchange Commission (SEC). It was created when Franklin Roosevelt overrode his advisors' counsel that government evaluate securities and, instead, opted for transparency to cure the stock market's collapse during the Depression. FDR fashioned the SEC—he called it the Truth Agency—to require corporations whose securities were publically traded to disclose results, using generally accepted accounting principles, audited by independent, certified public accountants and made readily available to the public. The Federal SEC superseded numerous, nonfunctional state and private transparency agencies, enabling a national capital market.

As in health care today, prior to the creation of the SEC, investors could access only the piecemeal data corporations chose to reveal. Because no generally accepted measurement standards existed, investors lacked a clear understanding of what the numbers meant and assurance that they were measured

comparably across firms.²⁵ Businessmen argued that the costs to them of this new agency would exceed its benefits.

Although the SEC failed as a regulator, it was successful in creating transparency, which, in turn, lowered the cost of capital, because investors who were more certain about performance, required lower returns; helped protect against misappropriation of shareholder returns by managers, as attested to by the outcries against CEO compensation, fueled by easily accessed mandatory disclosure about executive compensation; and enabled appropriate allocation of resources: investors rewarded productive, socially responsible firms more than others.²⁶

Objections to a Health Care Transparency

Why do we need government intervention for transparency?

Although the impact is uncertain, the available evidence suggests that transparency would produce a net good for consumers and health care markets, improving quality and reducing costs.²⁷ Governmental action is needed because, like a classic public good, the financial gains to providers from transparency are dwarfed by the public welfare it creates by increasing the quality of life.²⁸

Why not leave transparency to state governments?

The best health care providers, and often the lowest cost ones, are found in many different states and may excel in different types of care^{29,22} The Dartmouth Atlas and other researchers found, substantial variation in the quality of care among states.³⁰ While state level reporting could supplement national reporting, state transparency agencies that limit information to local providers may prevent insurers from creating multi-state networks of best value providers.²⁰

Will the costs of transparency exceed its benefits?

If the budget of the new transparency commission emulated that the SEC's billion dollar budget, estimates of the savings to be created by health care transparency easily exceed these costs. Further, by consolidating measures, transparency will likely reduce the sizeable expenses of private sector providers for collecting and reporting different measures for different insurers. The recent growth in Federal support for Health Information Technology will simplify the measurement process by automating retrieval of data now collected manually.

Health care is different. The average person will not use these data

The equilibrators of an effective market are not the average buyers but rather *marginal* consumers. At a high price, there are only a few buyers who are more or less price insensitive. To attract more customers, suppliers reduce their prices. The increased volume of customers more than compensates for price reduction. Suppliers continue to cut prices until they hit the last tough-minded customers who pay a price roughly equal to marginal cost.

The rest of us benefit from the relatively small last-to-buy crowd. A McKinsey study showed, for example, that only 100 investors "significantly affect the share prices of most large companies."³¹ These hard-nosed buyers are adept in finding, interpreting, and using information. The market for automobiles, a highly complex product, illustrates their impact. Automobile prices are the lowest in two decades while their quality is the highest.^{32,33}

Substantial evidence indicates that today's better-educated consumers also seek health information. In 2007, 28.7% of the population had attained a college education or more, and 85.7% were high school graduates.³⁴ In 1960, in contrast, fewer than half the people were high school graduates, and only 7% had a college education.³⁵ Higher levels of educational attainment

increase not only income and ability but also self-efficacy.³⁶ Affluent Web surfers spend more time than others searching for information on the Net, finding good values, and improving the product for everybody.³⁷ A 2009 report found that 61% of American adults used the Internet for health information.³⁸ Millions spent an average of 20 minutes at the government's National Institutes of Health Web site, studded with arcane medical journal articles,³⁹ and mastered medical skills, such as CPR and the use of external defibrillators.⁴⁰

More than 70% want online evaluations of physicians,^{53(p2)} and when they obtain the information, they use it.⁴¹ Consumers are willing to change hospitals in response to information about their quality.^{42,43,44} Consumers who had made relatively poor health care choices in the past, improved them when information was available.⁴⁵

Medical care outcomes cannot be accurately measured. Providers who treat high-risk patients or only a few patients will be unfairly penalized

More than two-thirds of surveyed physicians indicated that the general public should not have access "to information on clinical outcomes."⁴⁶ For example, one complained that the cost of collecting the data ranged from \$0.59 to \$2.17 per member per month. But the benefits likely far exceed these costs. For

example, if quality data improve the costs of treating a diabetic by as little as 1%, the data collection costs will be repaid fiftyfold in less than one year.⁴⁷ The same report also notes that many data cannot be reliably measured for most doctors because they treat so few of the sick: "a physician would need to have more than 100 patients with diabetes . . . for a profile to have a reliability of 0.8 or better, while more than 90% of all primary care physicians at the HMO [he studied] had fewer than 60 patients with diabetes."⁵⁹ A hospital-based study similarly concluded that "the operations for which surgical mortality has been advocated as a quality indicator are not performed frequently enough to judge hospital quality."⁴⁸

These challenges are real. Research is needed to mature the science of quality measurement and to minimize and account for systematic and random error, ensuring that variation in outcomes among providers represents true variation in the quality of care. In some care settings, outcomes may need to be aggregated to groups rather than individuals. To date, investments in advancing the science of quality measurement have been minimal.

But the purpose of performance measurement is to protect the patient, not the physician or the hospital. Transparency would likely cause the low-volume physicians, medical groups, and hospitals that cannot generate statistically reliable data

to lose patients to those who achieve excellent outcomes, in part because of their high volume, or to consolidate practices into larger groups. Providers who see many patients of one type are more likely to develop the expertise needed to care for them effectively and efficiently.⁴⁹

Why not restrict disclosure of the results to the providers and insurers? Why must the data also be reported to the public?

An evaluation of the impact on a Wisconsin quality improvement initiative which reported hospital performance data both publically and privately concluded that "Since quality improvement efforts among the public-report hospitals appear to be significantly greater than in hospitals given only private reports, there is added value to making performance information public."⁵⁰

Yet, the concerns about issuing misleading outcome data are real and valid. Undoubtedly, the science of quality measurement must improve before providers will be comfortable with the public release of outcome data. It is not that scientists cannot develop measures; it is that society has not invested in developing them. Surely, if we can sequence the human genome, all 3.4 billion base pairs with 99.999% accuracy, we can develop quality measures.

Health care quality measures are currently of insufficient quality

Some providers appropriately worry about the quality of the information. Much of the language for measuring health care quality has yet to be defined; the risk adjusters that would make it possible to compare the performance of high-risk specialists to those who treat less severely ill patients are not yet fully developed;⁵¹ raw data are often flawed; and data quality control is virtually nonexistent.⁵² These are serious concerns. For example, a study that compared the rates of caesarean sections in hospitals, with and without adjustment for the fact that some hospitals might have more patients prone to caesareans, found that adjustment caused the performance of a fourth of the hospitals to change dramatically :for example, 10% of those originally classified as especially high or low users of these surgeries were reclassified as normal and some classified as normal were reclassified as having greater or lesser rates of surgery than the average.⁵³ Physicians may be dissuaded from caring for very sick patients if outcome measures do not correctly reflect the severity of illness.

Measurement issues like these can be resolved with investment, time ,and experience as illustrated by the continual evolution in financial measures such as *beta*, the measure of risk of different investments. *Beta* has been continually

refined since it was first suggested in 1952 by people so expert that one of its developers won a Noble prize.⁵⁴

Conclusions

Although financial performance measures are not perfect, public disclosure forced them to improve continually over time. Absent governmental oversight, we have little hope that health care will significantly improve transparency. Consumers pay the price of the failure of health care transparency, sometimes with their lives, and frequently with their pocketbooks. And providers, payors, and regulators pay the price too by lacking data to effectively and efficiently improve quality and reduce costs of care. Health Care Transparency will enable consumers to make more informed choice, reduce health care costs, and hold health care insurers and providers accountable for the results achieved.

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Mr. PALLONE. Thank you, Dr. Herzlinger.
Mr. Cowie.

STATEMENT OF MICHAEL COWIE

Mr. COWIE. Thank you for the invitation. My name is Mike Cowie. I formerly served in leadership positions at the Federal Trade Commission. At the FTC, I supervised antitrust investigations in health care, so my testimony today is based on the perspective of antitrust.

In antitrust investigations, a major objective of the FTC is to protect consumers from collusion where competitors increase and harmonize their pricing. FTC attorneys and economists follow guidelines to determine whether particular industries are susceptible to collusion. One of the key factors is whether pricing terms are available and known among competitors. Collusion among competitors to raise prices is more likely in industries where pricing terms are known.

The FTC has opposed regulation requiring public posting of pricing terms, and this FTC price has cut across administrations. An example was a State law requiring liquor wholesalers to file price lists with the State beverage control agency. The FTC opposed that policy expressing concern that the availability of comprehensive price information tends to make it easier for industry members to coordinate pricing. That was in distilled spirits. The FTC has raised the same concerns in pharmaceutical pricing. The FTC staff has opposed State legislation requiring PBMs, or pharmacy benefit managers, to publish price discounts or price rebates received from manufacturers. The FTC warned that the public posting of precise details of rebates would make tacit collusion more feasible.

The FTC has not stood alone on this policy. The Department of Justice and the CBO have opposed regulation requiring public filing or Internet posting of price terms. For example, the CBO opposed a proposed policy to force Medicare drug plans to post data on price rebates negotiated from manufacturers. Like the FTC, the CBO expressed concern that manufacturers would probably reduce their largest rebates.

The views of the CBO, Justice Department and FTC are built on a wealth of empirical economic research. Economic studies have found that a mandatory publication of pricing terms often leads to higher prices for consumers. For example, in the 1980s the Federal Communication Commission required the long-distance phone carriers, companies like AT&T, Sprint and MCI, to file publicly the rates they charged businesses for long-distance phone services. Eventually economists and policymakers found that this led to higher prices and price stabilization.

In coming years, more Americans will have health insurance coverage including prescription drug coverage. Few will be paying retail or list prices. The role of well-informed, large and sophisticated purchasers such as PBMs or health plans will grow. Key pricing terms will be the product of head-to-head negotiations between drug manufacturers and PBMs. These pricing terms should continue to be set through the negotiation process not through public or Internet postings.

Of the pending bills, H.R. 4700 conflicts with established anti-trust principles designed to prevent collusion. It would require pharmacies, pharmaceutical manufacturers, insurance entities and others to post all of their pricing terms on the Internet. This requirement of Internet price posting may contribute to price stabilization and price increases. Thank you.

[The prepared statement of Mr. Cowie follows:]

Michael G. Cowie
Antitrust Partner, Howrey LLP

Before the U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

May 6, 2010

Chairman Pallone, Ranking Member Shimkus, and Members of the Subcommittee, thank you for the invitation to participate in today's hearing on pricing in healthcare. My name is Mike Cowie and I am an antitrust partner at Howrey LLP in Washington DC. I formerly served in leadership positions at the Federal Trade Commission (FTC). At the FTC, I supervised antitrust investigations in healthcare.

The Subcommittee on Health is considering legislation that would require healthcare companies to make public filings or internet postings of pricing terms.¹ My testimony today focuses on the evaluation of these types of pricing policies from the perspective of antitrust.

FTC Analysis. In antitrust investigations, a major objective of the FTC is to protect consumers from anticompetitive pricing through collusion -- that is, pricing determined jointly among competing companies rather than independently by each individual company. FTC attorneys and economists follow guidelines to determine whether industries are susceptible to anticompetitive price increases. One of the key factors is whether pricing terms are available and known among competitors.

Collusion among companies to raise prices is more likely in industries where pricing terms are known among competitors. If a company knows how its rivals set prices, that company may raise its own prices to meet those of its competitor. Why work to undercut the competition if you know customers will pay a higher price? Under the

¹ H.R. 4700, The Transparency in All Health Care Pricing Act of 2010; H.R. 2249, The Health Care Price Transparency Promotion Act of 2009; H.R. 4803, The Patients' Right to Know Act.

antitrust guidelines, the FTC treats collusion as less likely in industries with non-public or private pricing terms. An FTC investigation and the decision on whether to bring an enforcement action may turn on whether competitors have visibility into pricing terms, thereby raising a danger of collusion.

The FTC has opposed regulation requiring public posting of pricing terms. For example, the FTC staff opposed a state law requiring liquor wholesalers to file price lists with a state agency.² It expressed concern that “[t]he availability of comprehensive price information tends to make it easier for industry members to coordinate prices tacitly and to detect and discourage deviation from the consensus price.”³ The FTC raised the same concerns in pharmaceutical pricing. The FTC staff has opposed state legislation requiring pharmacy benefit managers (PBMs) to list in public filings the price discounts or rebates received from drug manufacturers.⁴ It warned that the posting of “precise details of rebate arrangements” would make “tacit collusion . . . more feasible.”⁵

Other Federal Agencies. The FTC has not stood alone on this policy. The Department of Justice Antitrust Division has opposed regulation requiring public filing of price terms.⁶ Likewise, the Congressional Budget Office (CBO) has recognized that mandatory posting of pricing terms may reduce incentives to discount. A few years ago the CBO evaluated a proposed policy to force providers of Medicare prescription drug plans to post data on price rebates negotiated from drug manufacturers. CBO expressed concern that “manufacturers would probably reduce their largest rebates because of the

² FTC Director of Regional Office, Statement to the Commonwealth of Massachusetts Alcohol Beverages Control Commission, June 26, 1996, www.ftc.gov.

³ *Id.* at 2.

⁴ FTC Office of Policy Planning, Letter to New York Legislature, Mar. 31, 2009, at 4-5, www.ftc.gov.

⁵ *Id.*; *see also* FTC Office of Policy Planning, Letter to Virginia House of Delegates, Oct. 2, 2006, at 13, www.ftc.gov.

⁶ U.S. Department of Justice, Comments to FCC, FCC Docket No. 90-132, Sept. 28, 1990, at 41, 44-46.

pressure that disclosure of such large rebates would place on their arrangements with other customers.”⁷ This “would tend to increase costs for both the Medicare program and, on average, for enrollees.”⁸

Economic Studies. The CBO and the Justice Department, like the FTC, have reasoned that posted pricing may reduce incentives to discount and contribute to tacit collusion. This view is built upon a strong foundation of economic research. Economic studies have found that mandatory publication of pricing terms often leads to higher pricing. For example, in the 1980s Congress required long distance carriers, such as MCI, Sprint, and AT&T, to file their pricing terms with the Federal Communications Commission (FCC). Economists and policy-makers eventually concluded that this policy caused long distance rates to converge and increase.⁹ Academic studies of posted-pricing policies in other industries have likewise reached the conclusion that such policies have in fact led to price stabilization and price increases.¹⁰

Pharmaceutical Pricing. To further the discussion of potential effects of transparency in healthcare, it may be helpful to examine the nature of transparency and competition in the biopharmaceutical sector. When choosing among medicines, patients and prescribers currently have access to a wide range of publicly available information about pricing. This includes information on pricing of prescription drugs at retail

⁷ Congressional Budget Office, Letter of Director Peter R. Orszag to U.S. House of Representatives, Comm. on Energy and Commerce and Comm. on Ways and Means, Mar. 12, 2007, at 4.

⁸ *Id.* at 4.

⁹ P.W. MacAvoy, *The Failure of Antitrust and Regulation to Establish Competition in Long-Distance Telephone Services*, 69-77 (MIT Press & AEI Press 1996); Hearing before the House Subcomm. on Telecommunications and Finance, Comm. on Energy and Commerce, 102d Cong., 1st Sess., June 19, 1991 (statement of Alfred C. Sikes, FCC Chairman); *Tariff Filing for Nondominant Common Carriers*, Notice of Proposed Rulemaking, CC Dkt. No. 93-96, 8 FCC Red. 1395 ¶ 13, 1993; Haring & Levits, *What Makes the Dominant Firm Dominant?*, FCC Office of Public Policy Working Paper No. 25, Apr. 1989, at 11-17.

¹⁰ Fuller et al., *Effect of Contract Disclosure on Price: Railroad Grain Contracting in the Plains*, 15 W.J. Agric. Econ., 265, 271, 1990; Albek et al., *Government-Assisted Oligopoly Coordination? A Concrete Case*, *The Journal of Industrial Economics*, Dec. 1997, Vol. XLV at 429.

pharmacies, drug coverage provided by PBMs or health plans, and co-pays or coinsurance. Ensuring consumer access to this information is critical.

Nearly every health insurance plan has a formulary, typically with tiered copays. Patients can find which copay or coinsurance amount applies to a given medicine. One example of this is the Medicare Plan Finder database. Information on coverage and copay levels is widely available to prescribers and is often accessed through handheld devices and e-prescribing systems. Notably, the use of tiered formularies has driven virtually all prescription drug utilization by insured persons to the tiers with lower out-of-pocket costs.¹¹

In contrast, public filing or internet posting requirements are ill suited for proprietary pricing terms negotiated in the pharmaceutical sector. Such public posting of pricing terms between manufacturers and sophisticated purchasing entities is unnecessary. These are the pricing terms negotiated between drug manufacturers and sophisticated purchasers – PBMs or health insurers. The arms-length negotiation process will lead to the best pricing outcome for consumers. The focus on pricing outcome is evident in the utilization pattern of medicines. IMS Health reports that in 2009, about three out of every four prescriptions used in the United States was filled with a generic.¹² The share of prescriptions filled by generics is expected to increase from this already high level over the next few years, as several brand drugs with large sales go off patent.

In coming years, more Americans will have health insurance coverage, including prescription drug coverage. This means the role of well-informed, large, and sophisticated purchasers will grow and more patients will obtain savings on prescription

¹¹ C. Baker, Drugs – Not the Cost Problem, Let's Talk Health Care, Apr. 13, 2007, www.letstalkhealthcare.org/prescription-drugs/drugs-not-the-cost-problem/.

¹² IMS Health, IMS Health Reports U.S. Prescription Sales Grew 5.1 Percent in 2009, to \$300.3 Billion., Apr. 1, 2010, www.imshealth.com/portal/site/imshealth/menuitem.a46c6d4df3db4b3d88f611019418c22a/?vgnextoid=d690a27e9d5b7210VgnVCM100000ed152ca2RCRD.

drugs, rather than paying retail prices. Pricing terms should continue to be set through the negotiation process, not public filings or internet postings.

H.R. 4700, the “Transparency in All Health Care Pricing Act of 2010,” in particular, would conflict with established antitrust principles designed to prevent collusion. It would require pharmacies, pharmaceutical manufacturers, insurance entities, and others to post all their pricing terms on the internet. The requirement of internet price posting – when applied to negotiated agreements between drug manufacturers and sophisticated purchasers – may well contribute to price stabilization and less discounting.

Conclusion. All consumers, particularly healthcare consumers, benefit from information enabling them to make informed decisions and to compare alternative suppliers and services. However, overbroad laws that require internet posting of price terms would undermine consumer interests. Public policy in healthcare should maximize incentives for vigorous price competition.

Mr. PALLONE. Thank you, Mr. Cowie.
Mr. Rugland.

STATEMENT OF WALTER RUGLAND

Mr. RUGLAND. Thank you, and good morning. My name is Walter Rugland and I am the non-executive volunteer chairman of ThedaCare, which is a four-hospital community-owned health system in Congressman Kagen and Petri's districts in Wisconsin. Prior to retirement, I served as executive vice president of Thrivent Financial for Lutherans. Before that I practiced nearly 25 years as a consulting actuary with Milliman. I bring that career expertise into play and my testimony here today.

ThedaCare has long been a proponent of greater transparency. I like to call it meaningful patient-focused information, and that is on the cost and quality of health care. We were one of the first health care systems in Wisconsin to publish data regarding costs and quality more than 10 years ago, and while not perfect, it was the best publicly available data at that time. ThedaCare became the founding member of the Wisconsin Collaborative for Health Care Quality in 2003 and the Wisconsin Health Information Organization in 2006, and Representative Baldwin described some of the activity of those organizations.

The commitment to transparency is driven by our strong belief that we must change to sustain our obligation of care for our community. We believe that change requires us to measure our performance in order to reduce our costs. Interestingly, when we thoughtfully changed to reduce our costs, our quality outcomes improved as well. Our commitment to tracking and reporting meaningful information meant people inside and outside our organization knew how well we were doing and where we needed improvement. In short, sharing the data held us accountable for our results.

Six years ago at ThedaCare, we shifted to a mindset of improving something every day, somewhere, something every day. It became catching, and today our culture thrives on improving. Our focus centers on the patient outcome, not the system outcome. The goal of a sustainable health care operation must be to reduce patient costs over time and foster a healthy community.

Some recent examples of what we have been able to accomplish—we developed a new model for our primary care clinics to complete the draw of blood, the diagnostics, the care planning within one visit. Patient dollar costs decreased and results improved. We used a similar approach to revolutionize our hospital design. Using a new model, we have eliminated errors during admission, medication reconciliation. We reduced our average length of hospital stay and reduced overall costs by more than \$2,000 per case compared to our traditional inpatient units. These and other continuous improvement efforts have earned us national recognition and we believe our success demonstrates the benefits of meaningful transparency.

In truth, exposure drives improvement, and in Wisconsin the exposure of cost and patient outcomes has played a key role in moving health care toward better patient value. It is one of the reasons that the Agency for Health Care Research and Quality now ranks

us as number one, and next week Caroline Clancy from that agency will visit our State to see this firsthand.

We believe health providers need to move toward transparency. We cannot continue to accept the myth that prices don't vary between providers, facilities or regions. Many who study health care costs report that costs are nearly 100 percent redundant, and our experience shows that exposure drives efficiency and thoughtful cultural change that produces better outcomes.

One of our challenges in creating meaningful information was the lack of common performance measures that would allow for comparison. Data must be patient centered and understandable in order to force providers to change and to better inform patients, and in Wisconsin we believe we have fixed that problem. Now it is time to address the same issues nationally. Without meaningful information, patients cannot make informed decisions. People make purchasing decisions for everything from banking to refrigerators based on cost and quality but that is not how it currently works in health care as we discussed today. They don't have access to useful and reliable information and we think that can be attained. If prospective patients knew how many medication errors a hospital made, for example, they might change where they go, and with meaningful information on health care cost and quality, patients would vote with their feet. Choosing providers that deliver the best value as insurance deductibles and coinsurance increase will be the case in the future. A patient's vote is more and more important.

In Wisconsin, we report on a full range of costs of care. The most meaningful cost data is fully loaded or all in the cost of a procedure or health service. Wisconsin has provided this on a retrospective basis with aggregate results by provider, institution or group. Interestingly, when we match the cost to outcomes, we see that poor-quality care costs more than high-quality care. To break the cycle of waste and inefficiency, we must set the stage to provide meaningful information about a patient's expected costs.

Our experience securing support for price and transparency legislation in Wisconsin underscores this is not a simple process. It is going to take a lot of work. We stand ready to serve and help in any way we can. Thank you.

[The prepared statement of Mr. Rugland follows:]



Mr. Walter Rugland

**Chairman of the Board
ThedaCare, Inc.**

Appleton, Wisconsin

**Invited Testimony
BEFORE THE U.S. HOUSE OF REPRESENTATIVES
Committee on Energy and Commerce
Subcommittee on Health**

May 8, 2010

Washington, DC

Good morning. My name is Walter Rugland. I am the non-executive volunteer chairman of the board at ThedaCare, a four-hospital, community-owned health system in Congressmen Kagen's and Petri's districts in Wisconsin. Prior to retirement, I served as executive vice president of Thrivent Financial for Lutherans, one of America's largest non-stock life insurers. Before that, I practiced nearly 25 years as a consulting actuary with Milliman. I bring that career expertise into play in my testimony here today.

ThedaCare has long been a proponent of greater transparency (I like to call it meaningful patient-focused information) on the cost and quality of healthcare. We were one of the first healthcare systems in Wisconsin to publish data regarding costs and quality more than 10 years ago. While not perfect, it was the best publicly-available data at the time.

ThedaCare became the founding member of the Wisconsin Collaborative for Healthcare Quality in 2003. The Wisconsin Collaborative for Healthcare Quality is a voluntary consortium of Wisconsin healthcare providers who publicly report performance data. ThedaCare also was a founding member of the Wisconsin Health Information Organization in 2006. The Wisconsin Health Information Organization is a statewide organization that is developing an all-claims, all-payers warehouse of health care data that will allow us to understand the cost and quality of care over an entire episode of care that may span several care settings — physician office, hospitals, rehabilitation, etc.

This commitment to transparency is driven by our strong belief that we must change to sustain our obligation to care for our community. We believe that change requires us to measure our performance in order to reduce our costs. Interestingly, when we thoughtfully changed to reduce our costs, our quality outcomes improved as well. Our commitment to tracking and reporting meaningful information meant people inside and outside our organization knew how well we were doing and where we needed improvement. In short, sharing our data held us accountable.

Six years ago, we shifted to a mindset of improving something, somewhere, every day. It became catching and today our culture thrives on it. Our focus centers on the patient outcome, not the system outcome. The goal of a sustainable healthcare operation must be to reduce patient costs over time and foster a healthy community.

Let me provide some recent examples of what we've been able to accomplish. We developed a new model at our primary care clinics to complete blood draws, diagnostics, and care planning within one visit. Patient dollar cost decreased and results improved.

We used a similar approach to revolutionize our hospital care. Using a new model, we have eliminated errors during admission medication reconciliation, reduced our average length of hospital stay, and reduced overall costs by more than \$2,000 per case, compared to our traditional inpatient units.

These and other continuous improvement efforts have earned us national recognition. We believe our success demonstrates the benefits of meaningful transparency.

In truth, exposure drives improvement. In Wisconsin, the exposure of cost and patient outcomes has played a key role in moving healthcare toward better patient value. It is one of the reasons the Agency for Healthcare Research and Quality now ranks Wisconsin as #1 in the nation for quality. Next week, Carolyn Clancy from AHRQ will visit our state to see this firsthand.

We believe health providers need to move toward transparency. We cannot continue to accept the myth that prices don't vary between providers, facilities or regions. Many who study healthcare costs report that costs are nearly 100 percent redundant. Our experience shows that exposure drives efficiency and thoughtful cultural change that produces better outcomes.

One of our challenges in creating meaningful information was the lack of common performance measures that would allow for comparison. Data must be patient centered and understandable in order to force providers to change, and to better inform patients. In Wisconsin, we believe we have fixed that problem. Now, it's time to address the same issues nationally.

Without meaningful information, patients cannot make informed decisions. People make purchasing decisions for everything from banking to refrigerators based on cost and quality information. But that's not how it currently works in healthcare. Patients typically don't have access to useful and reliable information on the price and outcome of the healthcare services they anticipate. Transparent data helps provide that information.

If prospective patients knew how many medication errors a hospital made, for example, they might change where they get care. With meaningful information on healthcare cost and quality, patients would vote with their feet, choosing providers that deliver the best value. As insurance deductibles and co-insurance increase, the patient's vote is more and more important.

The Midwest Business Group on Health identified three ways health plan purchasers may unknowingly promote poor quality:

- Making purchasing decisions based on price without also examining plan and provider performance;
- Focusing on transaction-based (rather than outcomes-based) payment structures that discourage overall quality improvement and promote waste;
- Missing opportunities to engage the consumer (employees and beneficiaries) on quality and cost issues.

In Wisconsin, we report a full range of costs of care. The most meaningful cost data for patients is the “fully loaded” or “all in” cost of a procedure or health service. Wisconsin has provided this on a retrospective basis with aggregate results by provider institution or group.

Interestingly, when we match the cost to outcomes, we have seen that poor quality care costs more than high quality care. To break this cycle of waste and inefficiency, we must set the stage to provide meaningful information about a patient's expected costs.

In the Wisconsin Collaborative for Healthcare Quality and the Wisconsin Health Information Organization, we have experienced firsthand the challenges and the value of developing and publicly reporting useful and meaningful information on cost, along with resulting outcomes and patient value.

Our experience securing support for price and transparency legislation in Wisconsin underscores this is not a simple process. The legislative journey in Wisconsin included a number of hurdles and barriers. We see similar challenges with a federal law being proposed.

For instance, we grappled with questions like these:

- What is the definition of price? Is it billed charges or billed charges with the average negotiated discount applied?
- Does the billed price for the same procedure at two different health providers include the same items?
- How do we incorporate quality and outcomes in the formula? Cost data by itself is dangerous.
- How do providers disclose prices and comply with the confidentiality provisions of their contracts with third party payers, and adhere to anti-trust laws?
- How do consumers find out the “all in” price of care versus having to search several sources to obtain separately the price and quality information on the physician services, the hospital services, the pharmacy – all the components of the care they receive over the entire episode of care?

We stand ready to work with HHS to bring meaningful information on costs to patients and providers. The government is an important partner, well positioned to reduce existing barriers and foster the free flow of transparent healthcare information. We believe our learning can help craft legislation that puts actionable information about costs and quality into the hands of patients and plan purchasers so they can make more informed health care decisions.

We know that healthcare providers use cost information to further drive quality and cost improvements within their own organizations. We believe the overall result of transparency legislation will improve the value of health care to the patient.

Don't let perfection be a barrier to progress. Improve upon what we have in Wisconsin. Keep working to make it better.

We invite you to visit ThedaCare to see firsthand what we are talking about and what we are doing. We also encourage you to contact other leaders in Wisconsin healthcare transparency.

Thank you, Mr. Chairman and members of the committee. I will be happy to respond to any questions you might have for me today.

Mr. PALLONE. Thank you, Mr. Rugland.
Mr. Gardiner.

STATEMENT OF TERRY GARDINER

Mr. GARDINER. Thank you, Mr. Chairman, and thank you for the invitation to be here. My name is Terry Gardiner. I am the national policy director for the Small Business Majority, which advocates on behalf of the interests of millions of small businesses in our country. My own personal background is, I have been a small businessman all my life both starting out as a self-employed commercial fisherman in Alaska and then a startup company and trying to provide insurance, and fortunately my company was able to grow so we had the beneficial experience of being self-insured, but I really sympathize with all those companies that never get that big, and I want to speak to why small business cares about this issue.

First of all, there are 22 million self-employed entrepreneurs in this country. They are basically in the very same boat as individuals and consumers that we all talk about except that they actually have to go buy their insurance in the individual market and try to navigate and make all these decisions about whether it is buying their insurance policy or navigating for them and their family the health care system. So we need to remember, there are 22 million self-employed that these issues apply to.

And then when we move up into the 6 million small businesses between one and 100 employees, the vast majority of them, 80 percent of them, have under 10 employees. You don't have an HR director or a CFO researching all these benefits, negotiating insurance, and at the same time when you are in a small business, your employees come to work. They are working, that is their job and they put everything into their job and they get their insurance through you. You are paying on average 75 percent as employer, they are paying 25 percent, and they come to you for help trying to figure out what is going on, how does the system work, why wasn't this reimbursed, what should they do. They turn to you. A lot of these are family and friends. They are people you know. It is not like you are in a big organization where you don't know people and you don't know their problems. So this is all very real for the small business out there and we have got 43 million people working at those small businesses between one and 100 combined with the 22 million self-employed, so this is a big problem.

I think from a business owner's standpoint, I think my own in the seafood industry, it is hard to understand why this would be so burdensome. I think everybody would like to have a monopoly and that is great, but most people in business function in a competitive world. In the seafood world, we as processors would buy seafood from small business owners, fisherman, and that is a very transparent price. You can go on the Internet and find out what the fish are selling. A lot of the fish is sold on auction and some of it is not, it is by negotiation, but that information you could go on the Internet and find all over the world what fisherman are selling prices their fish as small business owners to processors. At the same time, there are wholesale auctions and there is pricing infor-

mation about that, and the world doesn't come to an end, and if they need to, I guess there would be an antitrust investigation.

But the world goes on, and in our own industry we would have to make reports on wholesale prices and all of this to government entities. You see this in agriculture. And it works fine. It creates a competitive dynamic market. Individually, people as business owners like to not have to do more reporting on pricing and all of that but it is not going to come to an end. It actually makes for a healthy market, and it is fundamentally, this is what health care is all about from a small business point of view. It is about the cost. That is what is killing small business, and we see the health insurance exchanges as a great reform going forward but we need to combine this with this transparency of pricing if we really want to have these exchanges the 50 States are going to set up. Combine these and you are really going to create a marketplace, and I think that is going to give all of these millions of small businesses an ability which maybe now some governments, some very large organizations can negotiate, they can research, they can get pricing information but the millions of small businesses and tens of millions of employees that work for them and count on them don't have these advantages, and this would help create a more equal playing field for the small businesses.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gardiner follows:]

Testimony
Terry Gardiner

House Committee on Energy and Commerce
Subcommittee on Health
Thursday, May 6th, 2010

Transparency in the health care marketplace

H.R. 4700, The Transparency In All Health Care Pricing Act Of 2010; H.R. 2249, The Health Care Price Transparency Promotion Act Of 2009; And H.R. 4803, The Patients' Right To Know Act

Chairman Pallone, Ranking Member Deal, Members of the Committee, Congressman Dr. Kagen, thank you for inviting me to testify today on the importance of transparency in the health care marketplace.

My name is Terry Gardiner and I am the National Policy Director for Small Business Majority. Small Business Majority was founded by small business owners to present an impartial view of the issues that have the greatest impact on small businesses. Our recent focus has been finding a solution to the skyrocketing health insurance bills small firms have been facing over the past several years. In addition, we're working on strategies to promote entrepreneurship, improving access to capital and small business growth.

Our surveys of small business owners have consistently found the No. 1 problem facing small businesses is the cost of healthcare. Small business health insurance premiums have risen 113% over the last 9 years. This is an unsustainable trend both for small businesses and their employees.

What is clear is that we must address the underlying inflation that is driving the cost of healthcare premiums up and up. As business owners a logical place to start is by making sure the prices of health care products and service are transparent for both employers, who on average pay 75% of the cost of insurance and employees, who on average pay 25% of the cost of health insurance.

As business owners we function in a competitive world of where prices are known. In my particular industry, seafood, many products are sold on auctions around the world. These prices are reported daily, many times by government reports. The prices paid to fishermen are published as well as the wholesale market prices the seafood processors sell for.

As a business if we buy a vehicle, an airline ticket, fuel or borrow money we can easily find the price. We can compare prices and ensure we are getting a fair deal. The same goes for consumers when they shop for a car, a house or a home mortgage. Consumers can even compare products on independent websites on the cost and quality of many products. This creates a competitive and dynamic market place for both businesses and consumers.

But as a small business owner you can not do that for healthcare. The only thing we can learn is how much our insurance premium is going up each year. The employees who must pay their share of the insurance premium are in the dark also. Without any information on the cost of healthcare how can a business owner negotiate his healthcare costs? Small business owners are at the mercy of insurance brokers where they find few choices and little justification of annual rate increases.

Even worse off are the 22 million self-employed entrepreneurs that must buy their insurance in the individual market. They have even less information and resources to negotiate a fair price. The self-employed pay the highest cost of healthcare.

The largest employers, the federal government and those who self-insure can demand – and get – access to some cost and price data needed to make good, informed decisions and negotiate for the best possible coverage and cost. This is one-reason large employers, the federal government and the self-insured have lower prices of health care coverage than small businesses.

Thanks to the proliferation of technology, more data is available to more people than ever before. But, this technology still hasn't penetrated health care. An important first step to controlling healthcare inflation is establishing transparency in health care pricing. With price transparency, we can have a free and competitive healthcare market. Businesses and employees who both pay the costs of healthcare can begin to pushback when they know the source of prices increases of all products and services.

Thank you for recognizing the need for transparency in the health care marketplace for small businesses and entrepreneurs. I hope this hearing is only a start, and that you will continue to work for a transparent health care marketplace so that healthcare is affordable for small business owners and their employees. Entrepreneurs need a sustainable healthcare system so they can continue to start businesses, grow their business and create the jobs that our citizens rely on.

Mr. PALLONE. Thank you, Mr. Gardiner.

That bell indicates we have three votes but we are going to hear from Mr. Holden and then we will break for the votes and then we will come back and ask questions, so we are going to ask you to stay obviously. I mean, it could take about, I don't know, half an hour or even an hour for the three votes but we need to stay.

Mr. Holden, you are next. Thank you.

STATEMENT OF CHRISTOPHER HOLDEN

Mr. HOLDEN. Thank you, Chairman Pallone, Ranking Member Shimkus and other members of the committee. I appreciate the opportunity to be with you here today. I am Chris Holden. I am the CEO of AmSurg, headquartered in Nashville, Tennessee. AmSurg is a corporate partner supporting 203 ambulatory surgery centers located in 33 States and the District of Columbia. AmSurg is a leading operator, distinguished as having the largest number of ACSs in the sector.

Over 1.2 million procedures were performed in our centers last year. Approximately 10 to 15 percent of all colon cancer screening colonoscopies were performed in our centers as well as 3 to 5 percent of all cataract procedures performed in the United States last year.

I am here today in my capacity as a board member of the ASC Advocacy Committee, which is the voice of the ASC sector representing the ASC Association, State associations and leading ASC operations. We are privileged to be asked to provide this testimony and appreciate the opportunity to engage in the process.

I just want to begin by saying that ASCs have long recognized the gap in effective communication of transparency. As a group, we have supported H.R. 2049, the Ambulatory Access Act, which called for provisions very similar to those in H.R. 4803. H.R. 2049 specifically called for apples-to-apples comparisons of ASCs and HO, or hospital outpatient, department quality and coinsurance information. We have encouraged CMS to introduce quality transparency requirements and we have educated our physicians about those same requirements. We have developed our own voluntary reporting system, and today 20 percent of ASCs voluntarily report their data to the ASC quality collaborative using the six measures endorsed by the National Quality Forum, and that data is available online at ASCquality.org.

Why do we support transparency? We believe that policymakers should be asking the question of why 50 to 60 percent of procedures are performed in the most expensive setting today. If properly executed, we believe transparency will accelerate migration to high-quality, lower-priced modalities of care. If, for example, half of the Medicare cases currently performed in the hospital outpatient department setting migrated to ASCs, Medicare would save over \$10 billion over 5 years. Why? Because Medicare pays 42 percent less when procedures in freestanding ASCs.

We also believe transparency will tap low-hanging opportunities to improve our system. Using ASCs as an example, increased transparency will shine the light on the underutilized potential of lower priced, higher quality modalities of care.

ASCs, for those of you who are not familiar, provide surgical and preventive surgical services with no overnight stay. The modality is only 40 years old and it has rapidly expanded over the last 25 years. The primary drivers have been the migration again from high cost to low cost and the increased use of preventative care services available through ASCs.

By way of background, in the early 1980s less than 1 percent of all surgeries were performed in ASCs. Today, 35 to 40 percent and 25 million procedures are performed in freestanding ASCs. And you may also be interested to know that colon cancer mortality has declined over 40 percent since the mid-1980s directly correlated with proliferation of ASCs. With over 5,200 ASCs providing vital access to care across this Nation, ASCs are now an integral part of our health care system, and you should know that national providers like AmSurg are the exception and not the rule. The sector is relatively new and highly fragmented with 60 to 65 percent of ASCs classified as unaffiliated small businesses with no corporate or hospital partner, and today only 20 percent have some type of hospital partner.

That said, other nations are still looking to our model and seeking operators like me to give them advice on how to possibly duplicate the ASC model in their countries as a means to expand access, improve quality and control costs.

So where does transparency fit in? Despite the unprecedented migration and growth of the service, today over 40 to 50 percent of all outpatient surgical procedures are done in more expensive modalities and there has been no appreciable change in outpatient surgery market share between hospitals and ASCs in the last 3 years. So why the slowing in migration? We believe lack of transparency is a contributing factor.

As we move forward with transparency, we think we should highlight three things. Number one, that the out-of-pocket expense is considerably higher, especially for Medicare patients, treated in the hospital outpatient department setting versus the freestanding ASC. The difference can be one and a half to three times greater. A cataract procedure, for example, costs the patient \$300 more out of pocket versus the two modalities. Secondly, the Medicare program itself pays 42 percent more for the treatment of patients in the HOPD setting. And three, patients today, as has been mentioned over and over, have a difficult time making any judgment on what are the quality standards in one modality versus the next or from one center to the next.

As part of our next steps as a group, the ASC Advocacy Committee is supporting the Patients' Right to Know Act, H.R. 4803, and—

Mr. PALLONE. Mr. Holden, I don't know if you are almost done but—you are?

Mr. HOLDEN. I am.

Mr. PALLONE. Because you are almost a minute over.

Mr. HOLDEN. With that, I will just end and say thank you again for this opportunity. Thanks for the cue.

[The prepared statement of Mr. Holden follows:]



Good morning Chairman Pallone and Ranking Member Shimkus. I am Chris Holden, President and CEO of AmSurg and Member of the Ambulatory Surgery Center Advocacy Committee (ASCAC) Board. AmSurg operates 200 ASCs in 33 states. I speak today on behalf of the ASC Advocacy Committee, the voice for the ASC industry and comprised of leading ASC operators, state associations and the ASC Association working on behalf of the industry to raise awareness about the important role ASCs play within the health care system and community.

Ambulatory Surgery Centers (ASCs) are health care facilities that specialize in providing essential surgical and preventative services in an outpatient setting. With approximately 5,300 facilities across all 50 states, ASCs perform more than 25 million surgeries and procedures a year, which constitute about 35-40 percent of all outpatient surgeries. We have become a major component of the health care continuum and an essential point of access for important preventive benefits such as colonoscopies to detect colon cancer and cataract surgeries to repair eye sight. We are dedicated to providing high quality care to our patients at an affordable cost to them as well as private and public payors.

Despite our significant presence in the outpatient surgery sector, there is very little information available to patients about the relative price of services offered by the different types of providers in their community. Medicare and most insurers post information about the price paid by Medicare or the beneficiaries' out-of-pocket liability in the traditional silos of facility type rather than presenting information across settings. As a result, there is very little awareness of the significant savings available when patients choose to have their surgical service performed in the ASC setting. Under Medicare, there is a 42 percent difference in payment for a service performed in the hospital and the same service performed in the ASC setting. Medicare always saves money when patients choose an ASC for their outpatient surgery.

We believe that patients and their physicians can make the most informed decisions based on their clinical needs. That decision-making can be greatly enhanced if patients and providers can compare their options on the basis of price and quality. For this reason, the Ambulatory Surgery Center Advocacy Committee announced our support for the Barton-Stupak legislation, "The Patients' Right to Know Act" (H.R. 4803). The "Patients' Right to Know Act" is especially timely: the recent health reform legislation instructed the Secretary to report on quality measures and a system for linking payment to quality for the ASC setting by 2011. The program she develops for rewarding high quality and low cost should enable the Medicare program, patients, and physicians to make comparisons among all providers of surgical services--within

settings and across settings. Establishing the goal of transparency now will provide important direction for pay for performance programs in ASCs.

We believe this bill will empower patients with critical information in order to make more informed decisions on where to receive their care. In particular, it will provide consumers with information on the quality and price of services paid by private insurers, Medicaid and Medicare at hospitals and ambulatory surgery centers (ASCs). Providing this information will enable patients and their physicians to choose the highest quality, lowest cost setting appropriate for their care. For example, a patient contemplating cataract removal should be provided information on hospitals and ASCs in their area – health outcomes, patient satisfaction beneficiary cost-sharing and reimbursement to those facilities in an easy to understand manner.

Understanding Differences in Payor Mix

ASCs are licensed to treat patients who can receive care and return home on the same day of their surgery. Presenting information on the payor mix of services across settings requires an understanding of the types of services offered in each setting as well as payment and other policies.

Types of cases performed in ASCs

In 2007, forty-six percent of Medicare payments to ASCs were for eye procedures, primarily cataract removal/lens insertion (40 percent). Colonoscopy and upper GI procedures accounted for 25 percent of Medicare ASC payments in 2007. Cataract removal and colonoscopies, two services essential to the Medicare population, accounted for 57 percent of total Medicare payments to ASCs. Eye procedures are simply less common in the non-Medicare population, making the ASC payor mix more heavily weighted toward Medicare than the hospital setting. On the other hand, colorectal cancer screening guidelines call for testing to begin at age 50, meaning that centers focused on GI procedures will have a lower percentage of Medicare cases and higher percentage of private insurance. Colorectal cancer screenings remain underutilized in the Medicaid and indigent care populations, although we have made huge strides over the past decade to expand access to CRC screening. We are optimistic that a provision in the health reform legislation to waive the coinsurance for CRC screening will improve access to and utilization of recommended services.

Payment policies that affect site of service

In addition to differences in the types of services performed in ASCs and hospitals, payment and tax policy also has a strong influence on the types of patients treated in each setting. In the hospital setting, several important policies expand hospitals ability to care for the un- and under-insured. For example,

- Not-for-profit hospitals are obligated to provide a charitable benefit to maintain their tax-exempt status. Some experts suggest that the value of tax-exempt status is worth \$20 billion to the hospital industry.¹
- Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments were originally intended to compensate hospitals for the higher operating costs they incur in treating a large share of low-income patients. More recently, many policymakers present DSH funds as a mechanism to preserve access to care for Medicare and low-income populations by financially assisting the hospitals they use. The federal Medicaid DSH allotment for 2009 was approximately \$11 billion. Medicare DSH Payments are projected to be \$9.8 billion.²
- Medicare pays hospitals for a portion of their Medicare bad debt. As the only provider receiving bad debt payments, hospitals are partially shielded by federal subsidy when the facility is unable to collect the beneficiaries' coinsurance.

Each of these adjustments has a sound basis in Medicare policy; however, there are no companion policies to encourage other providers to subsidize the uninsured. While the hospital industry is primarily tax-exempt, most ASCs are for profit entities that pay federal, state, and local taxes. In addition, ASC owners pay taxes on their revenue from the facility as well. In some areas, states levy a tax on ASCs to pay for uncompensated care delivered in hospital settings.

Empowering patients with information on the price and quality of services will supplement the expanded coverage of the uninsured and help patients and payors stretch limited financial resources most efficiently.

Providing Meaningful Price Comparisons

Today more than ever, Americans are facing higher coinsurance or are covered under high-deductible health plans that expose them to significant out-of-pocket costs before coverage kicks in. Even in Medicare, out-of-pocket obligations are considerable. As a result, price has

¹ NANCY M. KANE, TAKING THE PULSE OF CHARITABLE CARE AND COMMUNITY BENEFIT AT NONPROFIT HOSPITALS, STATEMENT TO THE U.S. SEN. COMM. ON FINANCE 2 (Sept. 13, 2006) (estimating value of exemption from all sources as approaching \$20 billion per year)

² http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf, accessed 05/03/2010.

been an important determinant to whether patients seek important preventive services like screenings colonoscopies. We applaud the Congress for acting to eliminate patients' liability for services recommended by the US Preventive Services Task Force. In the outpatient surgery setting, this should be a tremendous benefit to increase the use of screening services for colon cancer that have been proven to be cost-effective measures to prevent colon cancer and reduce mortality. Despite tremendous strides in increasing screenings, there are still millions of Americans who are not receiving recommended screening services.

Providing meaningful information that allows patients to compare the price of services and their out-of-pocket liability should also allow patients to select the least costly setting appropriate to their clinical needs in consultation with their physician. Because many outpatient surgeries can be performed in hospitals and ASCs, it is critical to provide patients with meaningful price comparisons across settings.

Under Medicare, there is a 42 percent difference in payment for a service performed in the hospital and the same service performed in the ASC setting. Medicare always saves money when patients choose an ASC for their outpatient surgery. Beneficiaries can save even more. This year, a patient needing cataract surgery would face an average difference in copayment of 61%. When the service is performed in the ASC, the beneficiary would be liable for \$196; however, the patient would owe \$496 if the same service were instead provided in the hospital outpatient department. Building an awareness of this among the Medicare population and the physicians who refer patients can help the Medicare program leverage the buying power of its beneficiaries.

Comparison of 2010 ASC and HOPD beneficiary copayments

<i>HCPCS</i>	<i>Description</i>	<i>ASC Copay</i>	<i>HOPD Copay</i>	<i>Difference</i>
66984	Cataract surg w/iol, 1 stage	\$192.49	\$495.96	61%
43239	Upper gi endoscopy, biopsy	\$73.89	\$143.38	48%
45378	Diagnostic colonoscopy	\$76.05	\$186.06	59%
45380	Colonoscopy and biopsy	\$76.05	\$186.06	59%
45385	Lesion removal colonoscopy	\$76.05	\$186.06	59%
66821	After cataract laser surgery	\$46.81	\$104.31	55%
64483	Inj foramen epidural l/s	\$59.20	\$97.09	39%
66982	Cataract surgery, complex	\$192.49	\$495.96	61%
45384	Lesion remove colonoscopy	\$76.05	\$186.06	59%
29881	Knee arthroscopy	\$209.92	\$403.36	48%
63650	Implant neuroelectrodes	\$699.19	\$885.85	21%
29827	Arthroscop rotator cuff repr	\$327.64	\$804.74	59%

It is also important to present consumers the payment rates for procedures at the facility level. In Medicare, many components of the payment system adjust hospital and ASC payments

based on their geography (the wage index) or based on hospital-specific characteristics (outpatient hold harmless rates, cost-based payment, and other add-on payments). The wage index alone produces significant differences in the price of services at an ASC and HOPD within the same metropolitan statistical area as shown below.

Payment for arthroscopic procedure in selected markets (29828)

<i>Geographic Area</i>	<i>Payment</i>		<i>Ratio of ASC:HOPD Payment</i>
	<i>OPPS</i>	<i>ASC</i>	
Wheeling WV-OH (OH providers)	\$2,987	\$1,625	54%
Connecticut	\$3,719	\$2,041	55%
Wilmington, DE-MD-NJ (NJ providers)	\$3,543	\$1,891	53%
Pine Co., MN*	\$3,294	\$1,847	56%
* Reflects application of out-commuting adjustment of 0.0812 to rural MN index			
Values reflect final FY2010 IPPS wage index and proposed ASC CY 2010 wage index values			

If just half of the patients who sought surgical services in the hospital last year had instead gone to an ASC, the Medicare program would save Medicare about \$2 billion a year and the beneficiaries hundreds of millions of dollars in lower copayments.³ The transparency provided in your bill can generate even more savings for patients, Medicare and Medicaid as patients are empowered to select providers on the basis of price and quality.

Providing Meaningful information on Quality

In addition, ASCs welcome greater transparency on quality metrics. More than 20 percent of ASCs are voluntarily reporting results on ASC quality measures endorsed by the national Quality Forum (NQF) while our industry continues to urge the Centers for Medicare and Medicaid Services to implement a system for nationwide quality measurement. In addition, our patient satisfaction rates are better than 90 percent. An apples-to-apples comparison of ASCs to hospitals for similar procedures will provide critical transparency and encourage individual hospitals and ASCs to continue to improve their health outcomes.

CMS has the current authority to require ASC quality reporting but has not utilized it, and our industry has repeatedly encouraged CMS to implement a mechanism for ASC quality reporting. In addition, current law does not require CMS to collect and share comparable quality information from ASCs and HOPDs, diminishing the utility of having data from each setting. The

³ ASC Association analysis of comparing the ASC and HOPD cost of half of the procedures performed in the HOPD in 2008 which are eligible for payment in the ASC.

ASC industry supports H.R. 2049, the *Ambulatory Surgery Center Access Act*, which includes a provision similar to the requirements of H.R. 4803. The ASC Access Act would require CMS to present side-by-side comparisons of ASC and HOPD quality and beneficiary coinsurance in each geographic area. Like the *ASC Access Act*, the *Patients' Right to Know Act* will help facilitate meaningful comparisons of facility quality by requiring ASCs and hospitals to report similar information where appropriate.

Although CMS has not implemented quality reporting for ASCs, our industry has come together behind an initiative to develop quality measures and collect performance on those measures from centers across the country. Today, approximately 20 percent of the industry voluntarily submits quality data to the ASC Quality Collaboration on the 6 measures endorsed by the National Quality Forum for ASCs.

ASC Quality Measures Endorsed by the National Quality Forum

<i>Measure</i>	<i>Description</i>
Patient Fall in the ASC	The frequency of ASC admissions experiencing a fall while in the confines of an ASC
Patient Burn	The frequency of ASC admissions experiencing a burn, regardless of severity, while in the care of an ASC
Hospital Transfer/Admission	The frequency of ASC admissions experiencing a transfer or admission to a hospital upon discharge from an ASC
Wrong Site, Side, Patient, Procedure, Implant	The frequency of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event while in the care of an ASC
Prophylactic IV Antibiotic Timing	ASC admissions having an order for an antibiotic to help prevent surgical wound infection that received the antibiotic in the appropriate timeframe
Appropriate Surgical Site Hair Removal	The percentage of ASC admissions that had body hair removed with electric clippers or hair removal cream

As you move forward, we want to work with you to ensure that the pricing information disclosed is accurate presents the most meaningful comparison for consumer choice. We look forward to working with you to advance this bipartisan legislation that empowers patients and the providers who care for them.

Mr. PALLONE. I apologize.

I think there is only 6 minutes left, so I think we are going to break here. I don't know, it could be half an hour, an hour probably at the most, so maybe the best thing is, if you want to get some lunch and come back, or I don't know if you have enough time. But we do want you to stay, obviously, and thank you all for your testimony and we will anticipate the questions. So the subcommittee is in recess.

[Recess.]

Mr. PALLONE. The hearing is reconvened, and we left off by having all of our witnesses make their opening statements and now we will go to questions starting with myself. I will recognize myself for 5 minutes.

And I wanted to start with Mr. Cowie because I noted with interest your comment that price transparency in certain instances could lead to higher, not lower, prices for services. Many of us have long supported price transparency in the belief that this transparency would move the market towards lower prices, for example, in the area of prescription drugs, advocating for disclosing not simply the average wholesale price or even the average manufacturing price but disclosing what the real price is for the product, net of discounts, rebates and other price concessions. So could you explain your comment on how in certain markets transparency could lead to a price increase as opposed to a price decrease and what specific factors in these markets could make that happen and what we could do about it all in a minute or less? Do the best you can.

Mr. COWIE. Chairman, in your initial comments I think you made a reference to health care differing from TVs and car buying. Let me use the TV industry to illustrate the antitrust point. So big TV producers are Samsung, LG and Sony. They sell to big distributors. Those are folks like Walmart, Best Buy, Target, and us consumers looking for competitively priced TVs will comparison shop at Walmart, Best Buy, Target. We will use the Internet, and we want information and that is healthy. But if transparency is the goal, if that is the goal, then what you might recommend is Samsung, LG, Sony publicly disclose the pricing they have in details with the big distributions like Walmart, Best Buy and Target. Those details are subject of head-to-head negotiations between very large and sophisticated players, and in antitrust, we would rather have those types of deals remain private, and if we had Internet posting or public filing of those pricing terms, that would present a risk of collusion.

Mr. PALLONE. So I am not sure. I mean, I want to get a second question. You would advocate that we do that or not do that?

Mr. COWIE. We would advocate that we not just woodenly require disclosure of all pricing terms. We can have—when we shop for TVs, we have transparency, we can compare Best Buy to Target, we can—

Mr. PALLONE. You mean the basic retail price?

Mr. COWIE. Yes, but when we are talking about the price between the manufacturer and the distributor—

Mr. PALLONE. So you don't want that?

Mr. COWIE. Correct.

Mr. PALLONE. But you would have—you think the retail pricing should be transparent but not the larger wholesale deals? That is what you are saying?

Mr. COWIE. Yes.

Mr. PALLONE. Let me ask Mr. Summer a question. You actually commented on this but I wanted you to give us a little more information on how the health care reform legislation recently passed took steps towards greater transparency, and I am not suggesting that we don't need to do more. Otherwise we wouldn't be having this hearing today. But just give us what—talk to me about what steps the hospitals will be taking to implement the requirements under the health reform legislation that would make them more transparent and more meaningful to the public.

Mr. SUMMER. Thank you, Mr. Chairman. I think what we would see happening under that bill is more comprehensive information available that is right now available in some States and not all States, much like I spoke about Colorado, and I think the bill will provide opportunities for patients and their families to get access to—

Mr. PALLONE. Well, let me—I know I keep cutting you off, but it requires uniform definitions, description of all covered items and services including exceptions, the cost-sharing for benefits, the out-of-pocket payment structure, a facts label that has common benefit scenarios allowing people to compare coverage and prices for a typical episode, requires charity hospitals to charge uninsured individuals no more than what is generally billed to insured patients for the same services. You don't have a lot of time obviously but just some idea how you are going to implement these things, if you could.

Mr. SUMMER. Thank you, Mr. Chairman. I think that what we are looking for and what will come out of that is for this information to be available at the State level so that, as you mentioned in your remarks, it will provide some standardization of what that information is, some common definitions and then the information related to both the charges and the length of stay will then be available for consumers to look and check, also, I think the patient safety information, the quality information, and I think it is important to look at them differently because people can check out quality and patient safety information at any time but the pricing information is obviously related to the need for procedure and that will vary very much by the individual patient and the severity of their illness.

Mr. PALLONE. Are the hospitals going to have a problem doing this?

Mr. SUMMER. No, sir. In fact, already in over 40 States in the country, it is available right now, and you heard two examples here, Wisconsin and Colorado.

Mr. PALLONE. So it is really more a question of uniformity than anything else at this point?

Mr. SUMMER. Yes, sir, it is available and we see no problem with making it available and we think that would be a positive step towards transparency.

Mr. PALLONE. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Let me say for the record I think that the recently passed health care law is an unmitigated disaster, and we are going to go off the cliff.

Let me move in a direction. Let us talk about transparency. Did you know that the transparency provisions only rely to those who purchase their health insurance through the new State-based exchanges? Did you know that, Mr. Summer, that the transparency provisions in the law only pertain to those who purchase their insurance in the new State-based exchanges?

Mr. SUMMER. Yes, Congressman. Those apply to health plans. What I am talking about, what we are here—

Mr. SHIMKUS. Yes, but the question was on the law. The law says transparency only for the new exchanges, that there will be transparency for. So that is not my main issue but I just want to counter what my colleague was talking about, transparency, that the transparency provisions, why we had this hearing is because we blew away transparency provisions. We didn't address transparency provisions in the law.

Let me go to Mr. Gardiner real quick. I want to ask about in your Alaska fishing days. How many different businesses did you have an aggregate cost of over \$600 per year with?

Mr. GARDINER. Well, my last company grew from a startup over 23 years to \$125 million in sales.

Mr. SHIMKUS. So how many businesses—say when you first started, you know, if you just had a boat going out to fish, how many different, as a small business, self-employed, how many businesses would you deal with aggregate payments to of over \$600?

Mr. GARDINER. Well, the average commercial fisherman like I was would have one to six crewmen who legally are self-employed.

Mr. SHIMKUS. What about gas? What about feeding?

Mr. GARDINER. Yes, you would buy a lot of stuff, probably—

Mr. SHIMKUS. Food?

Mr. GARDINER. —a third of your expenses, you buy groceries, fuel every week.

Mr. SHIMKUS. Water, petroleum, a lot of different businesses that you would pay at least \$600 to annually?

Mr. GARDINER. That is correct.

Mr. SHIMKUS. As a small businessman, if you had to file a 1099 for each transaction, would you feel that that is an additional business obligation?

Mr. GARDINER. Well, we do as fish processors, we had to file every time we purchased fish from a fisherman, you know, every—

Mr. SHIMKUS. No, I am talking about for the food for your crewmen, for the gasoline you purchased, for the repair of your net.

Mr. GARDINER. No, we didn't have to.

Mr. SHIMKUS. But the point is, you will as a small businessman under this law, the health care law. If you have a contractual obligation of over \$600, you have to file a 1099. That is why we are going to hire 15,000 more IRS agents.

Mr. Summer, how many—in an individual hospital, how many individual contracts are payments out of over \$600 does an average hospital have in the State of Colorado?

Mr. SUMMER. Mr. Chairman, I have no idea. There probably are hundreds.

Mr. SHIMKUS. Given the potential paperwork nightmare this provision could become, would you commit to surveying your members to determine this figure?

Mr. SUMMER. We would certainly be willing to talk to you about that but, Mr. Chairman, also——

Mr. SHIMKUS. I am just the ranking member.

Mr. SUMMER. I am sorry, Mr. Ranking Member.

Mr. SHIMKUS. This is the chairman.

Mr. SUMMER. Congressman, thank you. The positive side for——

Mr. SHIMKUS. What I am asking is, I want—I would like for your help to determine all the individual contracts. Here is an example. If you cut grass in America and you are a kid and you have \$600 of gas bills to a retail location, you are going to be required to provide that gas station a 1099 under this bill. Now, just multiply that by the size of the business, and that is why the projection is 15,000 more IRS employees.

Let me move to Medicare and Medicaid real quick. You have heard us talk about the chief actuary of CMS and his projections that suggest that roughly 15 percent of Part A providers would become unprofitable. Do you have an identification? Do you, first of all, agree with that number, and which 15 percent of the hospitals of Colorado will basically close because of this new health care law?

Mr. SUMMER. I have not, Congressman, read that report but I think——

Mr. SHIMKUS. No, the CMS actuary did. The actuary for the Centers for Medicare and Medicaid Services, it is their projection based upon us taking \$500 billion out of Medicare. Wouldn't that be in effect, affect the cost of reimbursement to the hospitals in Colorado?

Mr. SUMMER. Congressman, we are so thrilled that there will be 32 million more people covered by that plan, that that is really the focus of our attention at the moment.

Mr. SHIMKUS. So you are unconcerned about the \$500 billion cut in Medicare or the trillion dollars additional in taxation?

Mr. SUMMER. Congressman, I think the net gain from that legislation is very positive for Colorado.

Mr. SHIMKUS. Well, you are speaking the policy line and I appreciate that, but I respectfully disagree.

My time is expired, Mr. Chairman. Thank you.

Mr. PALLONE. Thank you, Mr. Shimkus. I have to admit that when you were asking Mr. Gardiner about fisheries in Alaska, I turned around and I thought I was back on my—before I chaired the Health Subcommittee, I was the ranking member on Fisheries, Wildlife and the Oceans, and I was wondering what was going on there for a minute.

Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman, and with due respect to my colleague from Illinois, I would like to point out that section 2715 of the health care bill that he is referring to specifically applies not just to those plans that are part of the exchange but to all group health insurance plans which make up the vast majority

of health care that is provided in this country and so the point I think was not accurate.

I would like to start, Mr. Cowie, with you. I know that you spent a great deal of your life dealing with antitrust issues. In your statement, you talked about concerns about price fixing and collusion, which is always an issue in antitrust cases, but one of the things we know about this marketplace is that it differs from many other marketplaces that would be considered a free-market environment, which is not constrained by other external forces. We all know that the 800-pound gorilla in health care payment is Medicare, and we know that Medicare controls prices in every jurisdiction in this country because we see it from the hospitals and doctors that we represent. We also know that most private pay plans are driven from some derivative of the Medicare pricing formula from a baseline and then a multiplier. So I don't understand how giving consumers more information about the cost of health care in that environment is similar to giving people information about TVs and other consumer products that they are pricing. Can you explain that?

Mr. COWIE. Congressman Braley, health care sectors is distinguishable because Medicare and Medicaid plays an important role but, you know, at the FTC, we wanted to make sure consumers got the benefit of vigorous price competition, so competition between drug manufacturers, competition between hospital systems, competition between large physician groups remains important in health care just like it does in other sectors. Where publication pricing can become problematic is if you are dealing with parts of the industry where commercial suppliers are negotiating with other large commercial suppliers. In many cities in this country, there are only two or three hospital systems and those two or three hospital systems are negotiating pricing with Blue Cross, with Aetna or CIGNA, and those are big boys negotiating hard, and in general in antitrust, our view is if, you know, you are playing poker, you shouldn't have to show your cards. You actually get better outcomes if they are negotiating head to head privately.

Mr. BRALEY. Well, that may be true but I think you are focusing on primarily urban area if you are talking about the potential of three competitive systems within a marketplace because in rural parts of the country, you may be lucky to have one hospital in your community, and one of the other related problems we know, and this came out extensively during the health care debate was in many States like mine, 80 percent of the private coverage is written by one or two companies, and in that case you have an unnatural negotiating environment because you have got a dominant player that has much more leverage than the people they are negotiating with, and so, Mr. Summer, I would like you to comment on that because you represent a vast group of hospitals from large urban hospitals to hospitals that are in rural communities and may be dependent upon a lot of other facts that are affecting what type of services they can provide. Do you believe that more transparency in pricing is going to hurt the medical consumers in your State?

Mr. SUMMER. No, Congressman, I think that the transparency that takes place at the State level where they provide the range of charges for certain diagnoses that are adjusted do help patients

give them some indication of the ranges. However, the real issue is what health insurance plan they belong to, and like your question, the answer is, there are places where there are not choices of providers. That is where you need to go, and so it gives a range of what is available but there is really not a lot of choice on price.

Mr. BRALEY. Mr. Rugland, I want to talk to you about your statement about the commitment to transparency that you talked about in your opening statement: "Driven by our strong belief, we must change to sustain our obligation to care for the community." You talked about how quality improved as a related aspect of a commitment to pricing and to transparency in the way you price the services you provide and also emphasizing getting the most efficiency into the system. One of the things that was mentioned was a reference to taking \$500 billion out of Medicare over the 10-year cost that CBO scored this bill and yet many health care economists estimate that each year there is somewhere between \$500 and \$700 billion of inefficient or wasted services within the health care delivery system. So I would like you to comment on how becoming more efficient and becoming more transparent promotes quality outcomes, promotes efficiency in the system and achieves the goal that we all are looking for.

Mr. RUGLAND. Let me start out by saying it is our view there is a trillion dollars a year of waste within the medical system, the health care system. Fifty percent of the system is redundant and waste. When we started working on the issue of how will we sustain our health care in our community, which was about 7 years ago, I like to say it this way, we put a bet on the fact that the model was going to need to change. It would not sustain itself as it operated, that over time a patient would have more and more voice in what their health care decisions were, and in order for us to be positioned in order to deal with that, we had to do several things. One is there had to be more information available, meaningful information. The first step was to work with the hospitals in Wisconsin to gather data on cost and quality, and then we also had to go into our own system and change the way we did things so that we could redesign the process to remove the waste.

Now, one of the things we found out was that as we understand and had transparency about price and quality, and some of that information is in my written testimony, and we posted it in the hospitals and in the clinics, we got better. We found out that people working in health care don't want to be at the bottom of the rank, they want to be good. They are committed passionately to what they are working on, and they want to be better, and their response to posting this data was that we got better. So as we moved to change our processes, our quality got better and that was what I was trying to get at in my testimony.

Mr. BRALEY. Thank you, and I will yield back.

Mr. SHIMKUS. Mr. Chairman, can I ask unanimous consent just for 1 minute to address this language of law that was raised by—to my friend from Iowa, the out-of-pocket cost transparency provision in section 101014 only applies to insurance purchased through the exchanges. Section 10104 amends section 1311E of the bill which is the exchange section, which is the exact important reason

why the Green-Barton bill needs to be addressed because it will address transparency across the board to all insurers.

Thank you. I yield back.

Mr. PALLONE. The gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. Summer, the health care law we just passed imposes a 2.3 percent tax on medical devices when they are sold. Are hospital purchasers of medical devices?

Mr. SUMMER. Yes, sir, they do.

Mr. PITTS. Do you think it is likely or not likely at all that the medical-device manufacturers will pass the tax through to the purchaser of the product in the form of increased sales price?

Mr. SUMMER. Congressman, we are hopeful that does not happen.

Mr. PITTS. But you think it probably will?

Mr. SUMMER. I can't comment on that.

Mr. PITTS. You can't? OK. Well, would it be fair to say that the tax on medical devices will increase the cost of procedures at your hospitals because the cost of medical devices used in those procedures is higher?

Mr. SUMMER. Congressman, certainly all the components of a procedure including the medical devices are factored into the cost of what that procedure would cost.

Mr. PITTS. OK. Dr. Herzlinger, what are the proper roles of the government and the private sector in ensuring Americans have access to the information they need to make good decisions? Is there any information that if released could lead to collusion and increased costs for consumers? Should the government insist on keeping that kind of information private or pursue other responses?

Ms. HERZLINGER. Well, the danger of collusion is of course great in oligopolistic industries. If there is free entry in the market, if Mr. Cowie and I colluded on price, then Mr. Summer, Mr. Rugland, Mr. Gardiner could all enter the market and cut our prices. So the only circumstance where we could collude effectively is if he and I are the only participants in the market. In most of the American economy, that is not so. Health care, for example, the health care delivery system is hugely fragmented and famous for its fragmentation. We have over 700,000 physicians, over 5,000 hospitals. The danger of collusion which may be there in the pharmaceutical industry where a pharmaceutical company may hold a patent and be a virtual monopoly is not so in the rest of the delivery system. And in the rare cases where there has been transparency of prices and quality, prices have improved and quality has gone up in health care like the rest of the economy.

Mr. PITTS. What is the full range of information that Americans need to make good decisions about their health care?

Ms. HERZLINGER. They need to know the prices that they are going to pay, and the Indian hospitals, which are the hospitals in the country of India, are creating themselves to compete with the American hospital industry, they quote full prices. So if you were to go to India and say I needed open heart surgery, they wouldn't say to you, well, we can't give you a price. They would give you a price and they stick with that price. So clearly you need price information, but that is not enough. You need to know what the quality

is as well, and when it comes to insurance, we also need to know how good is that insurer in dealing with people like me, do they hassle people like me or are they great to people like me, how great are they to the doctors that I deal with. That is the kind of information we need.

Mr. PITTS. And is it preferable for the government to empower Americans with good information about the quality and cost of their health care or to task government bureaucrats with determining which procedures and treatments are cost effective and medically effective?

Ms. HERZLINGER. I think the models that we have in transparency elsewhere in the economy, for example, in the SEC. The SEC has the power to enforce transparency but it has ceded that power to professionals, in this case, the accounting profession who are not stakeholders and interested in preserving truth. It is solely interested in doing a good job of measurement. That is a very good model to follow.

Mr. PITTS. Finally, Mr. Holden, I understand Medicare pays ambulatory surgery centers about 58 percent of the hospital outpatient rate and that beneficiaries can save even more with their copays. What are the current obstacles to informing patients and other consumers of these potential savings and how would the Patients' Right to Know Act create a more informed consumer?

Mr. HOLDEN. The biggest obstacle is lack of a forum, lack of a vehicle for the communication. Right now it relies on the communication between the patient and the physician as a general rule, and even among physicians those are facts not well known and not facts well known in almost any forum in the country.

Mr. PITTS. My time is up. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and again, I would like to thank our panel for their patience. Between votes and everything else, it is sometimes hard to actually get a full hearing in a day, even with one panel.

Mr. SUMMER, both Congressman Burgess and I are original cosponsors on the Health Care Price Transparency Act, H.R. 4803. It is a State-based approach building on what we have. Could you discuss the difference between a State-based price transparency system such as your system in Colorado and a system, say, we would have at the Health and Human Services here in Washington, or HHS?

Mr. SUMMER. Thank you, Mr. Congressman.

Congressman, all decisions for health care are local, and the experience has been that a system that is built locally at the State level, and there are plenty of models to look at, are much more useful and helpful to patients and their families. So we believe that the State-based system which allows the hospitals to put the information in and aggregate it as is being done in almost 41 States would provide the better information for the consumers.

Mr. GREEN. H.R. 3590, the Patient Protection Act, created a system of State-based health insurance exchanges, and do you believe setting a federal floor on States that adhere to with regard to price

transparency is a logical way to proceed with price transparency even though those exchanges will be State based?

Mr. SUMMER. I am sorry. I couldn't understand the question, Congressman.

Mr. GREEN. The bill created a system of State-based health insurance exchanges, and is it better, would it be better to have federal, for example, minimum standards which we are going to have for those exchanges anyway? That is what current law—but transferring that into transparency, should we have some type of minimum amount of transparency that all States would have using the best of the 31 States we have, for example?

Mr. SUMMER. I think some federal guidelines, some uniform definitions would certainly help for the comparability of that information, yes.

Mr. GREEN. Of course, I say that because just a few days ago the governor of Texas decided he wasn't going to participate, and I am ever so thankful that we put in there that we will have a State exchange in Texas but it will be without State participation because obviously our small businesses and folks need it.

You referenced the need for a study of consumer-friendly pricing language or common terms or some sort of agreement among hospital providers on pricing language. Do you have any suggestions on the study or implementation using these common terms? It seems that universally common pricing language should be regulated or guidance should be issued by HHS so we would know across State lines whether it is a State exchange on the type of policy we are purchasing or the information that we are being provided, whether you are in Texas or Louisiana or New York.

Mr. SUMMER. Congressman, I think very much to your point, I think there needs to be some comparability, some standardization because borders are very porous when it comes to purchasing health care and using health care facilities. There is a distinction in our mind with borders but that is not how people buy health care and so there would need to be that standardization or some comparability between the terms and the information.

Mr. GREEN. Thank you.

Mr. Holden, how would the quality reporting requirement in the Patients' Right to Know Act regarding apples-to-apples comparison of quality metrics across sites of care create more useful quality information for a patient considering an outpatient surgery at an ASC or a hospital, and does the ASC industry have—what are they doing now on quality reporting? Because I think we know hospitals are having to do it. Are the outpatient surgical centers also doing it?

Mr. HOLDEN. Yes, sir. As I mentioned, we are reporting voluntarily about 20 percent of centers in the United States through the ASC quality collaborative posted online at ASCquality.org. In addition, we formed the ASC quality collaborative to pursue this initiative on our own, assuming that there may not be a forum like we have here today to discuss it and take it to the next level, so it is something that we have been pushing internally. I think the first part of your question is, what would it take to—

Mr. GREEN. To create these apples-to-apples comparisons, because consumers need both pricing information but they also need to know quality so they can make that informed decision.

Mr. HOLDEN. Obviously we need, as I think has been mentioned several times, the pricing information across modalities, and, you know, the NQF data is available today but we need to expand the data set. You would need to tailor it to a consumer-friendly, consumer-relevant set of metrics, like if you or I were sitting down trying to decide where do I get a cataract surgery, you would want to know—you wouldn't need that many data points much like, I think the example was given on the car. You know, if you had the various consumer reports and repair records and things like that, in a similar vein you could make those decisions pretty quickly.

Mr. GREEN. Well, and I know most people and I know in my own family if their doctor recommends some type of surgery, they are going to particularly go where the doctor suggests, but I think we are going to empower a lot more consumers to say if I need a bypass, I can tell you there are lots of facilities in Houston, Texas, than can provide bypass surgery, and both having the quality and the information there, particularly if they are having to pay, you know, their 20 percent copay. We know seniors now are concerned because they have to come up with that Medi-gap or that 20 percent on Medicare. A lot of folks, though, below 65, you know, don't do that. So I think the information we would provide by this legislation would help.

Mr. HOLDEN. There is no forum today, there is no place to go for that information across the outpatient platform. The best we could think of was doing it amongst ourselves but for it to be correct it needs to compare across all modalities, and we don't have the power to make that happen.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate your patience.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I have a particularly difficult task because I only have 5 minutes, and although we heard from Dr. Kagen on the first panel, there is no doctor on the second panel so I feel obligated to be that doctor on the second panel, so I may ask myself a few questions and respond because I think the doctor's perspective is important to have before the committee.

I just have to say one thing, too. Atul Gawande, who before he became famous for traveling to McAllen, Texas, also did some other travels, and I think it was 2004 wrote an article for the New Yorker called The Bell Curve, and I know I have heard Dr. Herzlinger speak of issues like this before, but to have the actual report card, if you will, on hospitals, on doctors so that consumers, patients can make the best choice if they are supposed to have a whatever, knee replacement, what have you, that they can then—you know, maybe they don't want necessarily the best price but they want to go to the place with the best results for knee surgery. Actually the article on the bell curve that Dr. Gawande wrote was on the treatment, the long-term treatment, the management of cystic fibrosis and how the very meticulous management of these patients could

actually translate into years added on to the end-of-life expectancy. So it is a theoretic point but it also has some practical applications, and Mr. Summer and Dr. Herzlinger, I wonder if you could just comment on that because that seems to be the direction of what we are discussing today. What about the concept of having a report card for your hospitals and for physicians?

Mr. SUMMER. Congressman, I will speak for the hospital side only, and I would say we could not agree with you more. In fact, that kind of information, we work with the State of Colorado and there are over three dozen quality measures available today on our web page that you can essentially slice and dice them any way to do any kind of comparisons among hospitals and procedures, so we fully support that. I think the basis for that is best done at the State level but that as you said in combination with the pricing information is important information and so we have moved forward and in collaboration with the State of Colorado to put that information and make it available today.

Mr. BURGESS. Thank you, and of course I know the physician's perspective and some pushback that would come from my community, but Dr. Herzlinger, let me even ask you from someone in the business world or perhaps even the patient's perspective, what about those type of models?

Ms. HERZLINGER. Well, clearly, patients love information. Consumers love information. That is what made Consumer Reports so powerful. It was a New York Times or Wall Street Journal article yesterday lauding Consumer Reports and other information intermediaries, people like JD Power, who is a real person, Bloomberg, those are people that take information that is provided by the government and they translate it and make it useful for consumers and they are well rewarded for their efforts. So consumers, when you look at surveys of what do they want in health care, one of the primary things they want from the government is they want transparency.

I would like to comment on whether the transparency should be State based or federal based. There are many good reasons for doing it by State but the Dartmouth atlas shows tremendous variations in the quality of care across States and across institutions. It would make sense for somebody who lives in Wisconsin on the border of Michigan to be able to have information so that they could compare the quality of information of health care, not only within their own State but in the growing market.

Mr. BURGESS. And I don't mean to interrupt, but I can't help myself. I have got to ask Mr. Cowie some questions, and I found myself intensely agreeing, intensely disagreeing with you as you gave your testimony. In fact, it reminded me of why in my first term I submitted an amendment to defund the Federal Trade Commission in one of our appropriations bill because of what you were doing to physicians and their inability to compete with insurance companies because we were never allowed to negotiate but of course insurance companies could do so freely. They could collude freely on price, but if doctors, even if there was a hint or a whiff that we were talking to each other, we would be hauled up before your commission, eventually cleared but not before we spent \$100,000 or \$200,000 which we couldn't afford.

But on the issue of not having data up there because it could lead to an unfair advantage to a third-party payer, I actually do support that notion and I worry that if I put my price for delivering a baby up on the Internet that I will give CIGNA, that United and Blue Cross will quickly say, hey, look what this guy will do this for and they will be right back in with a new contract that reflects that lower level, but the real problem is not CIGNA and Blue Cross. The big problem is the Centers for Medicare and Medicare Services and the sustainable growth rate formula which every insurance company in the country almost pegs to the SGR, and as a consequence when we cut doctors' pay 5 percent, 6 percent, 21 percent, which we are threatening to do at the end of this month, every insurance company out there in the country is salivating and rubbing their hands together because now they are going to be able to offer new contracts based on that percentage of the SGR formula. So really, shouldn't the FTC go after CMS with all the vigor that it attacked physicians a few years ago? And I know I am out of time but I would like to hear a response.

Mr. COWIE. Congressman, I would need to study that issue and get back to you to address it intelligently.

Mr. BURGESS. I will accept that deferral. It is—it does become—you know, this is a very, very complex problem. I didn't get to question the ambulatory surgery center but we have the whole issue of physician-owned hospitals which we have essentially outlawed in the health care bill and yet if you want the best bang for your buck, if I am uninsured and I need a moderate procedure done, I can get that procedure for one-tenth of the cost that I can get it in the hospital if I go to an ambulatory surgery center. The doctor's fee is likely to be the same in each facility because it doesn't matter to them. They are indifferent as to what facility they use, but the big cost driver is hospital versus the ambulatory surgery center. Not all facilities are equal, and unfortunately in the construct of this bill, we really didn't delve into why those differences exist and what we might do to mitigate them.

And Mr. Gardiner, I appreciate your comments as well. You talked about having a federalized exchange so that there would be—you wouldn't be beholden to State issues. I just wonder why we weren't able to ever talk seriously about selling insurance across State lines because that too would make sense. Now we have the federal government doing it for us. We might have had the private sector competing for us. Now we have the federal government which competes with no one, and I submit my previous issue on the SGR, but now we have the federal government that competes with no one setting those prices across the country and we may have gotten the absolute worst of both worlds.

I didn't get to talk about Medicaid, but I appreciate the extra time, Mr. Chairman. I will yield back.

Mr. PALLONE. Thank you.

I had a unanimous consent request from Mr. Shimkus to enter into the record the statement of Tim Estes and Travis Gentry, co-founders of Financial Healthcare Systems.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Without objection, so ordered.

Mr. SHIMKUS. Nothing, Mr. Chairman, except for instructions to the panelists that if we have follow-up questions—

Mr. PALLONE. Oh, yes. Let me mention that. I will remind the members that you may submit additional questions for the record to be answered by the witnesses, and those are submitted to the clerk normally within the next 10 days, so you may get additional written questions from us within 10 days. The clerk will notify you and obviously we would like you to answer as quickly as possible.

Mr. BURGESS. Mr. Chairman, I would ask unanimous consent that this op-ed that appeared in May of 2005 in the Washington Times that was well written and so well constructed and quoted Dr. Reinhardt, that that be inserted into the record.

Mr. SHIMKUS. Reserving the right to object, Mr. Chairman.

Mr. PALLONE. Let us look at it. Oh, it is by you? Oh, OK.

Without objection, so ordered.

Let me thank all of you for being here today. This is a very important issue. As I said in the beginning, we did have a legislative hearing on all three bills today because we know it is important and there is certainly a possibility that we would move forward with legislation. We are not clear on that yet but obviously today helped us in that regard a great deal, so thank you very much really for your testimony, and without objection, the subcommittee hearing is adjourned.

[Whereupon, at 1:00 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



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May 29, 2009

The Honorable Michael C. Burgess, MD
United States House of Representatives
229 Cannon House Office Building
Washington, DC 20515

Dear Congressman Burgess:

On behalf of the American Hospital Association (AHA), our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, I am writing to support your legislation, H.R. 2249, the *Health Care Price Transparency Promotion Act of 2009*.

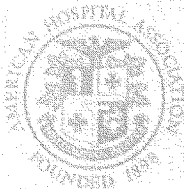
Consumers deserve meaningful information about the price of their hospital care and hospital leaders are as committed to sharing this information as they are to sharing information about quality. The AHA believes that the states, working with their hospital associations, are the best source for sharing meaningful pricing data. In fact, 34 states already require hospitals to report information on hospital charges or payment rates and make that data available to the public; an additional seven states have voluntary efforts. Your legislation builds on this existing structure, and also requires insurers to participate in the disclosure process by providing information on estimated out-of-pocket costs for health care services.

H.R. 2249 also requires the Agency for Healthcare Research and Quality to conduct a study on the types of price information that consumers want and would find useful in their health care decision-making. This is valuable because, while we have research on the kind of information consumers want about health care quality, we know less about what they might want to know about pricing.

We appreciate your leadership on this issue and we look forward to working with you to advance your legislation.

Sincerely,

Rick Pollack
Executive Vice President



Congressman Robert E. Latta
The Committee on Energy & Commerce
Subcommittee on Oversight and Investigations
Opening Statement – For the Record
May 6, 2010

MR. CHAIRMAN; RANKING MEMBER BURGESS: Thank you for holding this subcommittee hearing on the role and performance of the Food and Drug Administration in ensuring food safety. It is an honor to have been recently appointed to the Energy and Commerce Committee, and I look forward to working with all of you on the important issues that come before the Oversight and Investigations Subcommittee.

Incidences of contaminated food products are a serious concern for public health. Just this week, the FDA announced that contaminated materials were used in the production of several lots of pediatric Tylenol products, and about 1,500 lots of bottled products are currently being recalled. Furthermore, as the percentage of the U.S. food supply imported from foreign countries increases, and bio-terrorism continues to be a threat, food safety is a critically important issue.

Last summer, the House debated H.R. 2749, the Food Safety Enhancement Act, and it is expected that the Senate will soon take action on the legislation. I represent the largest agricultural district in the state of Ohio, and am a former member of the House Agriculture Committee. I was displeased that H.R. 2749 did not adequately address the concerns of the agricultural community, nor was it referred to the Agriculture Committee for any hearings.

Additionally, the Congressional Budget Office estimates that H.R. 2749 will authorize \$2.314 billion over Fiscal Years 2010-2014, and that it will take \$3.5 billion for the FDA to administer the new regulatory activities under this legislation during that time.

CBO also estimates that the president's budget plan will increase the public debt to \$20.3 trillion by 2020, and a \$655 billion deficit has been incurred in just the first five months of this fiscal year. Recently the President's Budget Director Peter Orszag, stated that "deficits of this size are serious, and ultimately unsustainable" and that significant changes in policy are required.

The spending level authorized by H.R. 2749 is of great concern to me, especially when the September 2009 GAO report found that gaps in enforcement and collaboration currently undermine food safety efforts among Customs and Border Patrol, the FDA, and USDA's Food Safety and Inspection Services. Furthermore, the same report indicates that there is a lack of information-sharing between the FDA and states during a recall, which impedes states' efforts to quickly remove contaminated food.

The safety and security of the nation's food supply is of utmost importance. However, with 15 federal agencies already administering at least 30 federal laws concerning food safety, I am concerned by the prospect of an increased size in bureaucracy, budget and statutory authority for the FDA when improvements in communication, collaboration and technology have been recommended by the GAO.

Mr. Chairman, thank you for this opportunity, and I look forward to hearing the testimony from the witnesses on the panel today. [Yield Back]



**Statement for the Record
Tim Estes and Travis Gentry
Co-Founders
Financial Healthcare Systems (FHS Corp)**

**Subcommittee on Health Hearing
Legislative Hearing on H.R. 4803, H.R. 4700, and H.R. 2249
May 6, 2010**

Thank you for the opportunity to provide testimony to the Subcommittee on Health hearing on Transparency in Health Care Pricing. We at FHS Corp design and sell our software, FHS ClearQuote™ to help healthcare providers estimate the patient's out of pocket at or before the time of service.

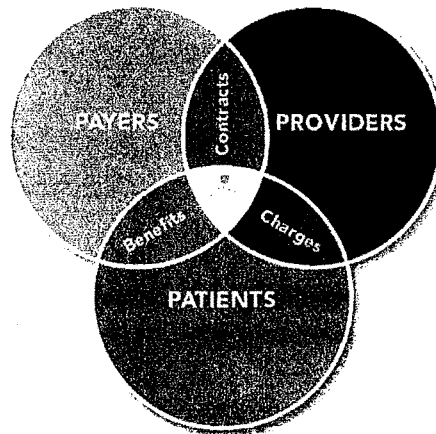
Do patients understand the concept of price transparency in the healthcare industry and the benefits they can gain from it? And how can providers prepare themselves for a movement toward patient consumerism? In the search for solutions, what are the different roles offered by technology and changes in process?

The concepts of price transparency and patient empowerment are both noble and basic to American culture. However, the transition from concept to reality contains significant challenge. Today, transparency has been defined simply the publication of provider charges. For self-pay patients, such a display of charges can be meaningful; however, self-pay patients represent only about 5 percent of the average payer mix. Growth of the self-pay population does not justify this weak solution to the issue of price transparency. True transparency occurs only when patients understand their out-of-pocket expenses ... not just provider charges.

Patients view healthcare as any other transaction ... with a buyer and a seller. Patients are the buyer and the providers are the seller. In the mind of the patient, the payer is just a third party to whom they or their employer has paid a health insurance premium in order to gain access to the provider. Patients are typically unaware of the complexities of the relationship between the provider and the payer, and they are specifically unaware of the way the payer-provider relationship affects the patient's out-of-pocket expenses.

If patients want to understand consumerism, they need to understand the unique relationships between the entities (contracts, charges, and benefits). To achieve transparency and empower providers and patients to work together, payers need to provide better access to patient eligibility information via Internet and 270/271 EDI transactions. Providers need tools that allow ready access to their contracts and charges to determine how a procedure will be paid. Integration of contracts, charges, and benefits provides all the necessary information for patients to evolve into educated consumers.

Typically, payers and providers store critical data from contracts, charges, and benefits in separate computer systems, even though integration of those systems could create meaningful information for patients. Today, several companies leverage technology to offer the healthcare industry a variety of pro-price transparency/patient consumerism tools. These robust tools include such features as demographic and address validation/correction, charity advisors, patient liability estimators, credit scoring, e-cashiering, and A/R segmentation. The tools are offered to providers on various levels, formatted for use by an individual organization or combined with others, and with integrated solutions. The needs and personality of the organization and its tendency to champion and adopt change will determine the best approach.



Payers and providers must embrace technology to be prepared to meet tomorrow's demands for price transparency and patient consumerism. Process creates change; technology supports change. The end result is an empowered healthcare industry prepared to educate and care for patients.

Estimating the patient's out of pocket up front, has two primary advantages: educating the patient and helping the provider collect from the patient. In today's market, collecting from patients is a necessity for healthcare providers. Payers are selling health plans that shift a greater burden of reimbursement from them to the patients. The condition of the economy has forced employers to reduce benefits which further shift more of the financial burden to the patient. Historically, the portion due to the hospital could be overlooked and not collected. Today, those dollars are the difference in reducing services, laying off employees, and even closing the hospital.

Patients are in an equal peril. The need to be transparent with cost and quality has been steadily increasing for the past five years. With the economy in a recession and high

unemployment, patient income and ability to pay their bills is at an all-time low. Nonetheless, patients have a right to know how much their healthcare will cost. Just like any other goods or service, patients have the right to shop and compare the cost and quality of their care amongst healthcare providers.

The responsibility is shared between the payers, providers, and patients. Payers need to make their health plan coverage and benefits more transparent to patient and providers. Providers need to communicate with each other more efficiently and leverage clinical and health benefit information to deliver estimates to patients. Patients need to understand their health plan and benefits and also set aside the financial resources to pay their bills.

FHS Corp fully supports the efforts of Representatives Barton, Green, Burgess, and Stupak and would encourage all members of the Energy and Commerce Committee to help H.R. 4803 become law. While the transparency provisions in the recently enacted health reform legislation are a small step in the right direction, we would challenge the committee to go further. Every patient should be presented with an estimate for their out of pocket cost. Limiting the requirement to the 29 million people buying insurance through the Exchanges is an extremely low goal. If the process to produce an estimate is efficient, the provider/payer industries should have to incorporate this as part of the continuum of care and part of a patient's bill of rights.

The payers and providers are mutually responsible in this effort of transparency. Providing only "charge" information to the patient population who have insurance is nothing short of irresponsible. Payers and providers negotiate the reimbursement of every procedure. Depending on that reimbursement contract, charges may not be applicable. The payers would have no incentive to provide this information to the patients and have no negative recourse if this information is less than credible. Payers need to provide efficient and comprehensive health plan and benefit information.

Payers are not the right organization to provide estimates to patients. Payers lack the information required to generate the estimate. Providers have the information and are the organization that patients look to for the estimate. Patients expect a "buy/sell" transaction like in every other aspect of their life. The hospital is the seller of the services and the patient is the buyer. Because of the patient's insurance, the patient will receive a discount based on the contract negotiated between the payer and the provider. The provider will send a bill to the patient and the patient owes the money to the provider. It makes no sense for the payer to generate and communicate an estimate to the patient when they "do not have a dog in the fight."

FHS Corp also supports enacting the provisions of H.R. 4803. Whether a patient is under-insured or has no insurance at all, incorporating a financial analysis provides a clearer picture for the provider as to the resources of the patient. This will help by obviously subsidizing those who may need some financial support. It also allows a provider to avoid a potentially

embarrassing conversation when the patient has no ability to pay. This financial analysis may not completely offset the financial requirement; it may just reduce the obligation owed.

