

Mr. Chairman, members of the Committee, thank you for this opportunity to testify this morning. My name is Gerard Anderson and I am a professor in the Bloomberg School of Public Health and a professor in the School of Medicine at Johns Hopkins University. I am also the Director of the Johns Hopkins Center for Hospital Finance and Management.

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

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

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

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

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

Each year we use the article in Health Affairs to investigate why health care in the United States is so much more expensive compared to the other countries. We have investigated a number of hypotheses including: malpractice costs, defensive medicine, aging of the population, the lack of waiting lists in the United States, the obesity levels in the United

States, and the high level of technology that is available in the United States. We have investigated each of these factors in one or more of the articles.

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

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

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

In 2004, we published an article in Health Affairs entitled Doughnut Holes and Price Controls which compared the drug prices for the 25 most commonly prescribed drugs (both brand name and generic) in the United States to the drug prices for the same 25 drugs in Canada, France and, the United Kingdom. What the article shows is that ***the United States patient is paying approximately double the prices for drugs as patients in Canada, France and the United Kingdom are paying.*** This explains the desire for reimportation among United States consumers.

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

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

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

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

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

Policy Initiatives To Control Prices in the United States

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

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

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

Because the private sector is paying higher rates than the public sector, the public sector has difficulty keeping prices low. If the public sector was paying substantially lower rates then the hospitals and physicians could restrict access to public beneficiaries. The differential between the public and private rates cannot become too great. The public and private sectors need to be able to work together to keep prices low. In the United States this means ***the private sector becoming a strong force in controlling prices.***

Does the United States Get Value For the Higher Prices?

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

For years we have known that the life expectancy is lower in the United States than in many other industrialized countries and that the infant mortality rates are generally higher. This would suggest that we are not getting value for the much higher spending in the United States. Critics of these comparisons have correctly pointed out that life

expectancy and infant mortality rates are determined by many factors and that health care may play only a minor role.

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

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

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

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

Pricing Transparency – What Else Is Needed

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

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

established by hospitals and doctors generally do not reflect what insurers are actually paying.

Comparison Shopping

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

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

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

Hospitals

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

1. The typical hospital bill contains 10 to 500 items. These could be \$1000 for an hour of operating room time or \$5 for a Tylenol. The patient will never use most of the items on the charge master file. Without knowing what services he/she will use it is impossible for the patient to do comparison shopping.
2. Unfortunately, in most cases ***hospitals and/or the doctor cannot tell the patient in advance which services they will need.*** The hospital or the physician may estimate that the procedure may require an hour of operating room time but the operation may require only 30 minutes or may require two hours. The hospital or the physician cannot know if the patient will want or need a Tylenol. Without knowing precisely what services are going to be used it is impossible to really do comparison shopping. Should the patient compare prices for 30 minutes, 60 minutes or 120 minutes of operating room time? Should the patient compare prices for Tylenol or ibuprofen?
3. Comparing the 10,000 to 50,000 items on the charge master file is foolish when the patient will probably use less than 100. The problem is that the patient does not know exactly which 100.

4. Many of the items on the charge master file and ultimately on the hospital bill are written in code so that only the hospital administrators and a few other experts in the field can understand. ***The charge master file will need to be translated if the consumer is going to understand what he/she is buying.***
5. I examined a hospital bill for a person who was charged over \$30000 for an outpatient procedure. A \$30000 charge for a procedure that did not even require an overnight stay.
6. The bill contained numerous charges. Many of the services on the bill were written in a strange language. I wonder how many people in this hearing room know what a “Bairhugger upper body cov” is or why the charge is \$77.55. The same hospital bill contained the following items and associated charges:
 - a. Furosemide/20MG/2ML/V – \$4.54
 - b. Toradol 30MG/ML 1ML S - \$ 22.02
 - c. Versed 1 MG/ML 2CC VIA - \$11.37
 - d. Lactated Ringers 2B2324 - \$189.00
 - e. Valve IV - \$7.15
 - f. Pack Custom Cysto - \$58.00
 - g. Set Tur - \$35.35
 - h. **Zofran 1 Mg dose – 155.18

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

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

Physicians

1. In most cases it is the physician who is making the decision about what type of care the patient will receive. The physician is unable to provide any guarantees in most cases concerning what services he/she will ultimately provide. As a result, comparative shopping will be impossible since you do not know the prices of what services to compare.
2. ***Comparison shopping for certain physician services is possible.*** Probably the best example is LASIK surgery. It is a relatively standard procedure and therefore it is possible for the physician and the patient to compare services and compare prices. In this case a price list is probably sufficient. LASIK, however, is more the exception than the rule.
3. The more common encounter between a physician and a patient is when the patient does not exactly know what is wrong and the physician has to order a series of tests to discover what is wrong and then to decide on the appropriate

treatment. This cannot be predicted at the beginning. Then once the treatment starts it is often unclear what will be needed and how long it will take.

4. For example, each woman with breast cancer will probably respond differently to treatment. As a result, the oncologist cannot specify in advance what services will be provided or what will be charged. If a woman was trying to comparative shop for an oncologist she would need to know what services will be provided and not just the prices that will be charged for services that she may or may not need. The same principle applies to people with chronic conditions such as diabetes, congestive heart failure, or asthma. No physician can tell the patient in advance what services he/she will require in the next year and therefore true comparison shopping will be impossible.
5. In the Medicare program ***two thirds of Medicare spending is by the 23% of beneficiaries with 5 or more chronic conditions***. These beneficiaries see an average of 13 different physicians during the year. Their condition is always changing. ***It will be impossible for these beneficiaries to predict what services they will need in the coming year and therefore comparison shopping for physician services is impossible.***

Pharmaceuticals

1. The Medicare Modernization Act allows Medicare beneficiaries to compare drug prices in different health plans. Many consumers have found this comparison shopping very difficult.
2. The drug plans participating in Medicare Part D do not have to disclose the price that they are paying for the drugs. All that is provided to the Medicare beneficiary is the retail price. Drug plans are likely to obtain discounts from the pharmaceutical companies.
3. Medicare beneficiaries are locked in to a specific drug plan which they choose based on the prices of the drugs and the cost sharing arrangements. However, the drug plans are free to change prices and change cost sharing arrangements during the year. ***A drug plan that was the least expensive for a beneficiary with one set of prices could become a very expensive plan if the drug plan changed the prices during the year or changed the cost sharing arrangements.***
4. Next year another problem is likely to arise – ***Medicare beneficiaries developing new diseases which require new drugs that they did not anticipate.***
5. A major problem for Medicare beneficiaries doing comparative shopping is that they are locked in to a particular plan for a year. Many have found the least expensive plan assuming their use of drugs does not change during the year. However, for millions of Medicare beneficiaries the drug regimen is likely to change and at that time they may not have the least expensive plan.
6. Unfortunately, Medicare beneficiaries get sicker as they age. Some years they develop a new chronic condition and that chronic condition may require them to take a new drug or multiple new drugs. The typical Medicare beneficiary acquires an additional chronic condition every two or three years. As noted earlier in this testimony, 23% of Medicare beneficiaries have 5 or more chronic conditions.

These beneficiaries fill an average of 50 prescriptions during the calendar year. Many of them change prescriptions during the year.

7. Without knowing what drugs you are going to use in the year it is difficult to do comparative shopping.

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

Reasonable Prices

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

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

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

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

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

One reason for not using costs is that they do not encourage efficiency. The prices could be high because the hospital is very inefficient. A second reason for not using costs to determine if the price is reasonable is that costs may not reflect market forces. A hospital with very high costs may be unable to lower its prices sufficiently to enter into an agreement with a health plan or an insurer.

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

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

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

How Charges Are Set By Hospitals

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

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

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

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

"With over 45,000 items in the charge master, the vast majority have no relation to anything, and certainly not to cost."

"There is no rationality to the charge master and costs still do not have much relevance."

"Charges have less and less meaning each year..."

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

The same Wall Street Journal article includes a chart that shows the variation in charges in seven California hospitals for services such as chest x-rays, complete blood count, CT Scan, Tylenol, etc. The chart below shows the variation in charges at the seven California hospitals for just Tylenol and a chest x-ray. The range for one tablet of Tylenol was free to 7.06. The range for a routine chest x-ray was from \$120 to \$1519.00. These are substantial charge variations.

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

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

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

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

Why Hospital Charges Are Set So High

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

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

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

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

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

By 1960 most hospitals had moved away from a per day charge and were using a charge master file to bill patients. In 1960, however, the charges set by hospitals were still based on the cost of providing care plus a small allowance for profit. Most insurers continued to pay charges. The charge master listed all the services the hospital provided for the patient: ibuprofen, multivitamins, Roloids, etc.

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

The hospital bill was calculated by multiplying the amount on this charge master file by the number of units received. For example, if the hospital charged \$1000 per day in the hospital for room and board and the person remained in the hospital for 4 days, the room

and board charge would be \$4000. Two hours in the operating room might cost \$500. Other services the patient received would be added to this bill to calculate a total charge.

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

Fewer and Fewer Insurers Pay Full Charges After 1960

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

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

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

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

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

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

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

First, Medicare created the Prospective Payment System for inpatient hospital services in 1983. In 1990, the Medicare program moved away from paying costs for outpatient services and instituted the Ambulatory Payment Classification System that sets rates for outpatient services. Most Medicaid programs adopted their own Prospective Payment Systems.

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

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

Comparing Hospital Charges

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

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

Self Pay Patients

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

Because the federal government, state governments, private insurers, or managed care plans do pay full charges, the regulatory and market constraints on hospital charges were virtually eliminated. Each insurer has developed a different way to pay hospitals; this

lead to a phenomenon known as “cost shifting”. The self pay patients continued to pay higher and higher charges as hospitals “shifted” costs to self pay patients.

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

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

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

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

Ratio of Charges to Costs

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

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

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

Table 1 also shows that charges were increasing much faster than costs in most states during the 2000 -2003 period. The relationship between charges and costs was continuing to erode over this time. In New Jersey, for example, the ratio of charges to costs increased from 3.16 in 2000 to 4.51 in 2003. In other words, the markup over costs increased from 216 percent to 351 percent over a three year period in New Jersey. Other states had similar increases in their ratios of charges to cost.

What Can Be Done To Improve Price Transparency?

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

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

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

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

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

This could solve both problems that I have mentioned. The patient would know the price of one provider relative to another provider. The patient would not have to know the price for any specific service; instead the patient would know how the prices generally at one hospital compare to the prices at another hospital. Second, ***it would be obvious when a provider set a price that was not in the market range.*** It would be

obvious that hospitals and physicians are charging patients much more than what insures such as Medicare are paying.

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