



HOSPITAL PRICING BEHAVIOR AND PATIENT FINANCIAL RISK

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EXECUTIVE SUMMARY

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

- **Hospital Pricing Behavior**

- Nonprofit hospitals charge patients less than for-profit hospitals (including effective net prices after discounts).
- Nonprofit hospitals admit more uninsured patients and provide more uncompensated care than for-profit hospitals.
- Prices bear little relationship to the actual cost of care. Some specialized services, such as burn units and neonatal intensive care are “money losers”; others, such as cardiac surgery and radiological imaging services, are highly profitable.
- Pricing, uncompensated care, and bill collection practices vary widely across nonprofit hospitals. The burden of caring for patients who cannot pay is unevenly borne; academic health center hospitals provide more uncompensated care than community hospitals.
- The financial stability of hospitals varies widely. Some are in serious financial difficulty, others are on the margin, and others are doing well. Hospitals in the best position are not of the best quality or the most efficient, while those doing the worst are largely shouldering a disproportionate share of charity care.

- **The Market for Hospital Services Is Different**

- Hospital care is not like consuming other goods and services.
 - Key differences include lack of information, limited choice, complexity and life-critical importance of health care treatment decisions, physicians’ decision-making role, and the need for insurance to protect financial security.
- Trying to make the market work by shifting costs to patients will inflict greater financial burdens on the sickest and most vulnerable people. Doing so does not lead to better decisions about seeking “appropriate” or “inappropriate” care and will not solve the fundamental problems of access, quality, and efficiency in the health care system.

- **Consumer-Driven Health Care**
 - High deductibles, cost-sharing tiering, or premium-tiering are unlikely to be effective in improving health system performance. They run the risk of increasing financial burdens on the most vulnerable patients.
 - Tiering, or varying cost-sharing according to hospitals' quality and efficiency, requires detailed information on cost and quality at the hospital or diagnostic level. For the most part, these data are not systematically available. Even were such data available and accurate, this presumes that very ill, hospitalized patients are able to evaluate cost and quality tradeoffs, have a wide range of options about where to go when hospitalized, and are able to make cost-conscious choices. Furthermore, the administrative costs of such a system would be high.

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

- **Historical Perspective on How We Got Where We Are**
 - Hospital costs grew at a slower rate during the Nixon Economic Stabilization Program, legislative consideration of the Carter hospital cost-containment bill, enactment of the Medicare DRG payment system, and, during the mid-1990s, under the threat of health reform and expansion of managed care.
 - Hospital costs grew most rapidly during periods when prices were determined by health care providers rather than purchasers.
 - All-payer strategies, especially those by selected states in the 1970s and 1980s, were effective in slowing cost increases, ensuring access to care, and improving equitable payment across patients and insurance sources.
 - The basic lesson from these experiences is that government leadership matters. When government establishes a payment framework for purchasers—whether Medicare, Medicaid, or employer health plans—and uses that collective purchasing power to obtain better prices from providers, the rise in

hospital costs is slowed, there is greater equity, and there is better access to care for the uninsured.

- Large purchasers such as Medicare, national managed care plans, and large employers can also obtain good deals on their own, but they are less effective both in controlling overall cost increases and in ensuring equitable payment and access.

- **Achieving a High-Performance Health Care System**

- Given the resurgence in health care costs, the increasing numbers of uninsured, abundant evidence that the quality of care is not what we could have and have a right to expect, and the fact that administrative costs are now the fastest rising component of health care expenditures, it is time to consider a leadership role for the federal government in promoting efficiency and quality in the health care system.
- The greatest promise for improving the performance of the health care sector lies in:
 - Public information on quality and longitudinal efficiency (i.e., total cost of care over an episode of illness) of all health care providers.
 - Private and public insurance incentive payments that reward hospitals and other providers demonstrating superior quality and efficiency. Purchasers are in a far better position to promote better quality and efficiency than are individual patients.
 - Limits or bands on how much prices can vary depending on payer source. Net charges to uninsured American patients should not be higher than discounted charges to insured patients.
 - Preserving and strengthening a predominantly nonprofit hospital and health care sector. It would be reckless to undo tax preferences for nonprofit hospitals, given that they are a major source of uncompensated care and community benefit. Such hospitals may reasonably be asked not to charge uninsured patients more, to work out feasible repayment plans, and not to employ unreasonable collection tactics.
 - Investing in the capacity to adopt modern information technology and systems to ensure safe care. It might be useful to consider a new “Hill–Burton” act—perhaps one that, in exchange for a new charitable patient care obligation, provides grants and loan capital funds for investment in information technology and systems to ensure patient safety.
 - A system of automatic and affordable health insurance coverage for all.

HOSPITAL PRICING BEHAVIOR AND PATIENT FINANCIAL RISK

Karen Davis

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

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

Today, I would particularly like to address current concerns about hospital pricing practices as they affect patients; review why the market for hospital care is fundamentally different from that of other goods and services; place the U.S. hospital cost experience in

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

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

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

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

an international context; and provide a historical perspective on how we got where we are today. I would also be pleased to share some thoughts on issues regarding price transparency, pay-for-performance pricing, pricing guidelines, the importance of the safety net provided by nonprofit hospitals, and health care financing. In particular, the greatest promise for improving the performance of the health care sector lies in:

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

HOSPITAL PRICING BEHAVIOR

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

In the intervening years, numerous studies have confirmed these basic conclusions. A recent meta-analysis of studies on payments for care at for-profit and private not-for-profit hospitals from the mid-1960s to the early 2000s concluded that

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

nonprofit hospitals tend to charge less and collect lower payment rates from patients than for-profit entities do.⁶ For-profit hospitals have higher profits and administrative expenses.⁷ A meta-analysis has also shown that quality of care is better in nonprofit hospitals, resulting in lower risk-adjusted mortality rates.⁸

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

Also troubling is that hospital charges bear little relationship to the actual cost of care—some services are very profitable and others are not. Specialized services such as burn units and neonatal intensive care are “money losers,” while cardiac surgery and

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

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

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

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

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

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

radiological imaging services are highly profitable.¹² Not surprisingly, “niche providers,” such as heart hospitals, orthopedic hospitals, surgical hospitals and ambulatory surgery centers (ASCs), cancer hospitals and centers, dialysis clinics, pain centers, imaging centers, and mammography centers, have been created to provide only those services that are highly profitable. This further reduces the ability of “full-service” hospitals to cross-subsidize care that is unprofitable.

In addition, managed care has made it more difficult for institutions that provide care to the uninsured to cross-subsidize uninsured care from payments for insured patients. Hospitals charge and collect very different prices for the same service depending on the source of insurance—in-network commercial insurance, out-of-network commercial insurance, negotiated contracts with different insurers and managed care plans, Medicare, or Medicaid—or the lack of any coverage. This practice might be viewed as equitable if net prices (after discounts) were systematically lower for poor patients and vulnerable elderly patients. However, uninsured patients are sometimes charged higher prices than privately insured patients, and some insurers get better breaks than others regardless of their enrollees’ income. This is one factor in the higher premiums charged for small businesses than for large businesses for the same benefits.¹³

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

¹² Commonwealth Fund Task Force on Academic Health Centers, *Health Care at the Cutting Edge*, Commonwealth Fund, July 2000.

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

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

THE MARKET FOR HOSPITAL SERVICES IS DIFFERENT

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

Key differences include:

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

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

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

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

The presence of health insurance also makes the market for health care fundamentally different. Hospital care is typically covered by insurance, subject to deductible or coinsurance amounts. Protection against most of the cost of hospital care is essential to achieve one of the basic goals of insurance—to ensure financial security in the event of a serious illness or injury. Increasing how much patients have to pay out-of-

pocket puts the patient at greater financial risk and may undermine the basic purpose of having insurance. Furthermore, cost-sharing for hospital care puts greater financial burdens on the sickest and most vulnerable people who have the least discretion in their use of care.

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

Nor are higher deductibles the answer. One-third of insured hospitalized patients with a deductible of \$1,000 or more would spend more than 10 percent of their income out-of-pocket.¹⁶ This is a financially burdensome exposure; it effectively leaves people underinsured.

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

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

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

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

CONSUMER-DRIVEN HEALTH CARE

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

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

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

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

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

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

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

Consumer-driven health plans are still in their infancy and not a great deal is known about them.²² Fewer than 3 million people were enrolled in such plans in 2003, out of more than 160 million enrollees in employer health plans. In general it appears that enrollment is relatively limited when such plans are offered as an option; healthier and higher-income individuals are more likely to enroll; and those who do enroll are relatively satisfied with the choice and reenrollment rates are high.²³

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

Tiered premiums have advantages over tiered cost-sharing in that they require decisions at the time of insurance enrollment rather than hospital admission. However,

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

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

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

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

they have many of the same information requirements and would need to be structured in a way that does not penalize those who cannot afford a higher-quality, but higher-cost, provider.

INTERNATIONAL EXPERIENCE

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

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

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

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

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

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

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

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

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

- U.S. hospital CEOs are much more negative than their counterparts in Australia, Canada, New Zealand, and the U.K. about their nation's health care system
- The U.S. is the only country where hospital CEOs cite the cost of indigent care and care for the uninsured as major problems
- U.S. hospitals are in somewhat better financial position, on average, than hospitals in other countries, but this varies across hospitals
- U.S. hospitals are more likely to experience emergency room diversions and turn patients away

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

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

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

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

- U.S. hospitals are more concerned about stand-alone diagnostic or treatment centers and freestanding ambulatory care centers “creaming” profitable patients
- U.S. hospital CEOs are less open to public reporting of quality information than CEOs in other countries
- Hospital CEOs in all countries would place a high priority on investing in information technology should resources become available to do so.

HISTORICAL PERSPECTIVE ON HOW WE GOT WHERE WE ARE

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

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

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

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

The second attempt by the federal government was the proposed Carter Hospital Cost Containment Act, which was considered by Congress from 1977 to 1979. The legislation would have placed a limit on the rate of increase in payments to hospitals tied to market basket inflation. But the legislation failed when the hospital industry mounted a “Voluntary Effort” to control costs. During this period, increases in hospital costs adjusted for economy-wide inflation rose 3.1 percent annually. But defeat of legislation ended the “Voluntary Effort” and hospital costs subsequently rose 7.8 percent in real terms in the 1981-1983 period.³⁴

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

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

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

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

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

margins, but they proved to be unsustainable.³⁷ A pushback by providers led to a resurgence of health care costs in the early 2000s.³⁸

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

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

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

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

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

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

undermine important social missions, including the promotion of cutting-edge research, education, and excellence in patient care.

PUBLIC POLICY OPTIONS

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

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

Price Transparency

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

What is needed is not so much information on prices of individual hospital or physician services—which are often meaningless—but information on the total cost of

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

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

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

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

But efficiency is not the only important dimension. Quality is equally important. Steven Grossbart at Premier, Inc., recently demonstrated wide variation in both cost and quality across Premier hospitals.⁴⁴ For example, he found a five-fold variation in poor outcomes adjusted for complexity for coronary artery bypass graft, and a two-fold variation in cost per case, similarly adjusted for case-mix complexity.

One of the difficulties with generating this information is the absence of a multi-payer claims data base with unique provider identification. One important step would be

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

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

for Medicare to lead in forging a collaboration among Medicare, Medicaid, and private insurers to assemble such a multi-payer claims database and make it widely available to researchers and providers. After improving the accuracy and validity of the data, public information on provider quality and efficiency could be a very strong motivator for improvement. A thoughtful middle ground has been proposed that would:

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

Pay for Performance

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

There are more than 75 pay-for-performance programs across the U.S. including those that are provider-driven (e.g., Pacificare), insurance driven (Blue Cross/Blue Shield in Massachusetts), and employer driven (Bridges to Excellence).⁴⁶ The new Medicare Modernization Act also calls for demonstrations to provide bonuses to physicians on a

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

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

per-beneficiary basis when quality standards are met. Several states have built performance-based incentives into Medicaid contracts, including Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin.

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

Pricing Guidelines

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

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

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

Preserving and Strengthening the Safety Net

In the current environment, nonprofit hospitals that provide uncompensated care to the uninsured and fulfill other vital social missions should be preserved and strengthened. It would be reckless to undo tax preferences for nonprofit hospitals. They are a major source of uncompensated care and community benefit. The current community benefits standard is broader than just charity care—some hospitals make a contribution through provision of high-cost “unprofitable” services such as burn care and trauma care; others make a contribution through medical education and training health professionals.

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

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

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

Alternatively, the disproportionate share allowance for hospitals could be better targeted, for example, providing payments at some percentage of the Medicare DRG payment rate for each uninsured patient served. Some portion might be specified for investment in modern information technology or systems to prevent medical errors. These measures are not just important in the short term. Even as we move to improve insurance coverage, it is important to preserve the safety net to ensure that health care is open to those who are difficult to insure—immigrants, the homeless, the mentally ill—and that all patients can receive patient-centered, culturally competent care.

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

Insurance Coverage and Access to Care for Vulnerable Populations

We will never have an efficient and equitable system so long as millions of Americans go without health insurance coverage. Over 85 million Americans are uninsured at some point over a four-year period,⁴⁸ and millions more are underinsured. Two of five Americans are struggling with medical bill problems or paying off medical debts. Tinkering with hospital prices and cost-sharing will do little to solve this problem. A

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

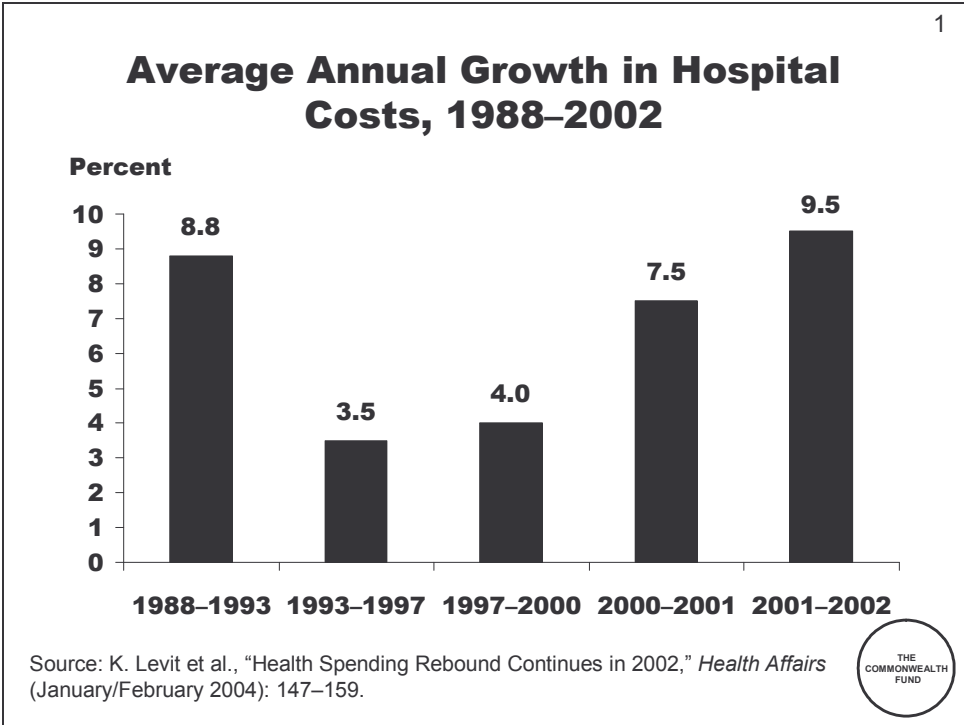
bolder strategy is urgently needed. Fundamental reform requires automatic and affordable insurance coverage for all. Thank you for the opportunity to be here today.



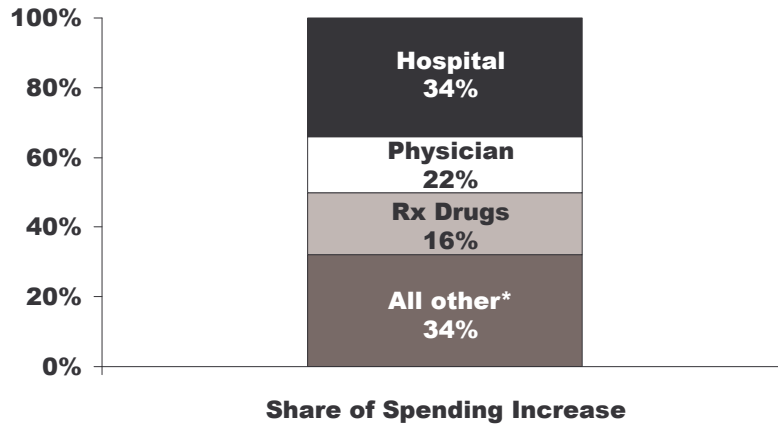
Hospital Pricing and Patient Financial Risk

Karen Davis
President, The Commonwealth Fund
June 22, 2004

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

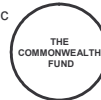


Hospital Costs Are a Major New Source of Increased Outlays, 2002

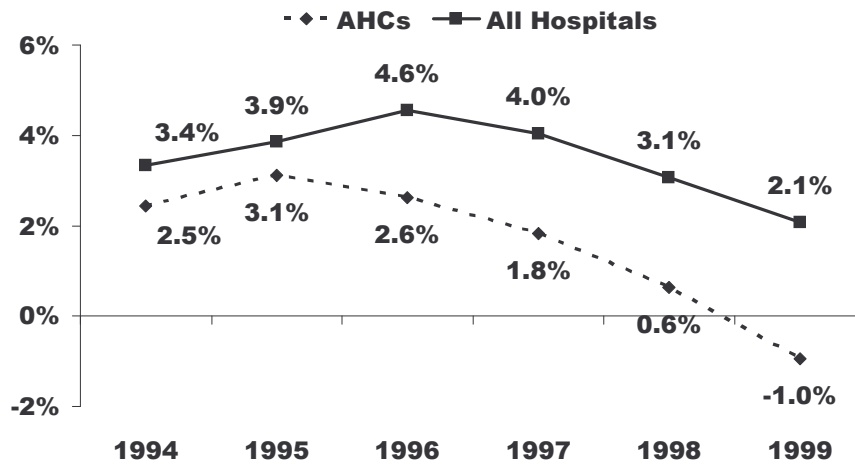


* Includes spending for dental, other professional, and other personal health care services; home health and nursing home care; durable and other nondurable medical products; administration and insurance net cost; government public health; medical research; and medical construction.

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



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

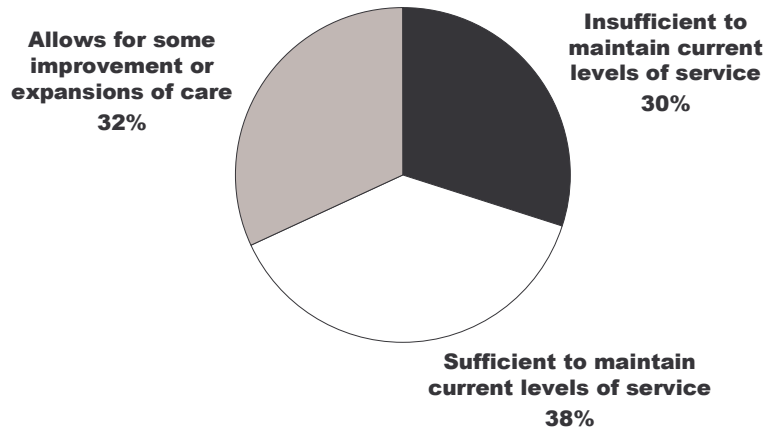


Note: Operating Margin = (Net revenue - Non-operating Revenue - Hospital Expense)/(Net Revenue - Non-Operating Revenue). AHC includes reported community hospitals data only; Total includes reported and imputed community hospital data only.

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



Current Financial Situation of U.S. Hospitals

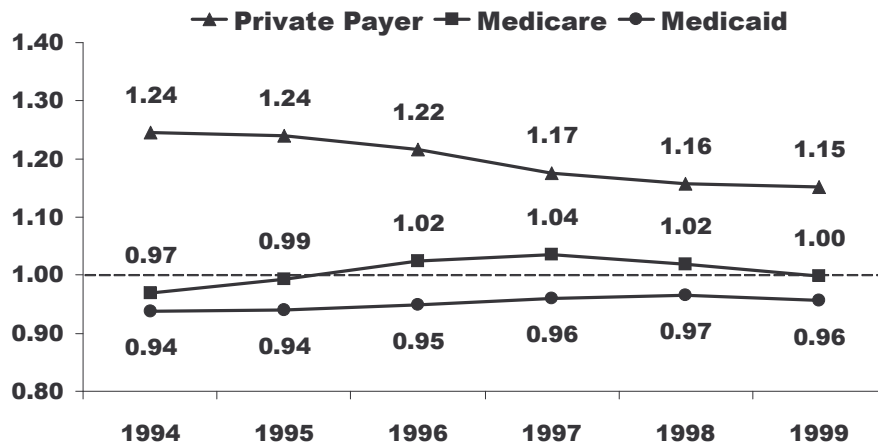


Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital CEOs.



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

Payment to Cost Ratio

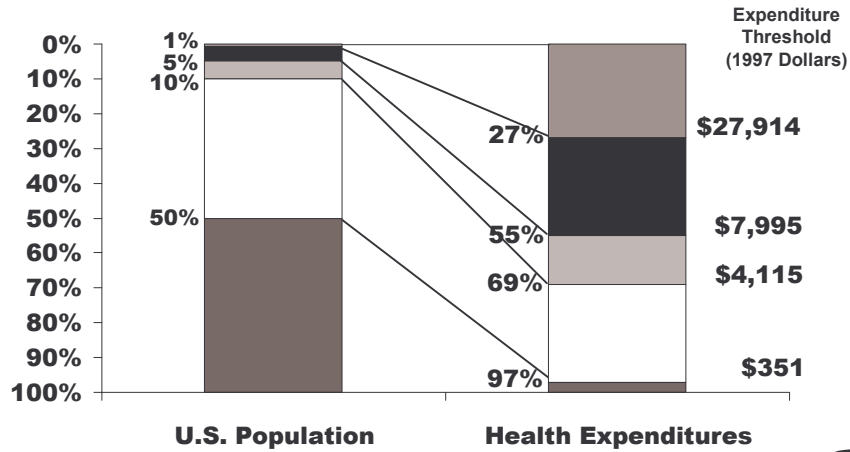


Note: Includes reported community hospital data only.
 Source: Commonwealth Fund; Report by Allen Dobson, Lane Koenig, Namrata Sen, Silver Ho, Lewin Group, Analysis of AHA Annual Survey data.



Health Care Costs Concentrated in Sick Few ⁶

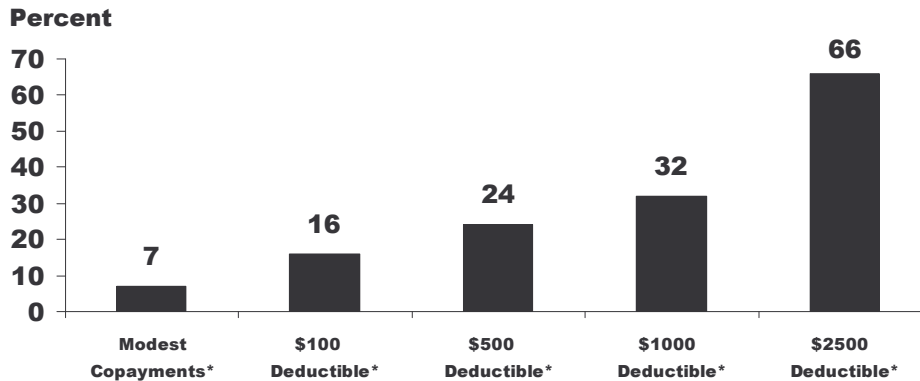
Distribution of Health Expenditures for the U.S. Population, By Magnitude of Expenditure, 1997



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



Percent of Hospitalized Patients with Out-of-Pocket Costs Exceeding 10% of Income by Cost-Sharing Amount ⁷



*** Notes:**

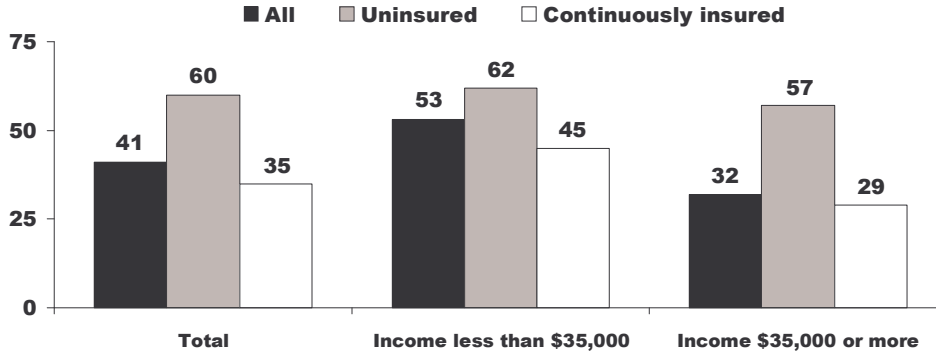
Modest Co-payments Option has \$20 co-pay for physician visits, \$150 co-pay for ED visits, and \$250 co-pay per day inpatient hospitalization; \$100 Deductible Option has 10% in-network coinsurance and 20% out-of-network coinsurance; \$500 Deductible Option has 20% in-network coinsurance and 30% out-of-network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

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



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

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



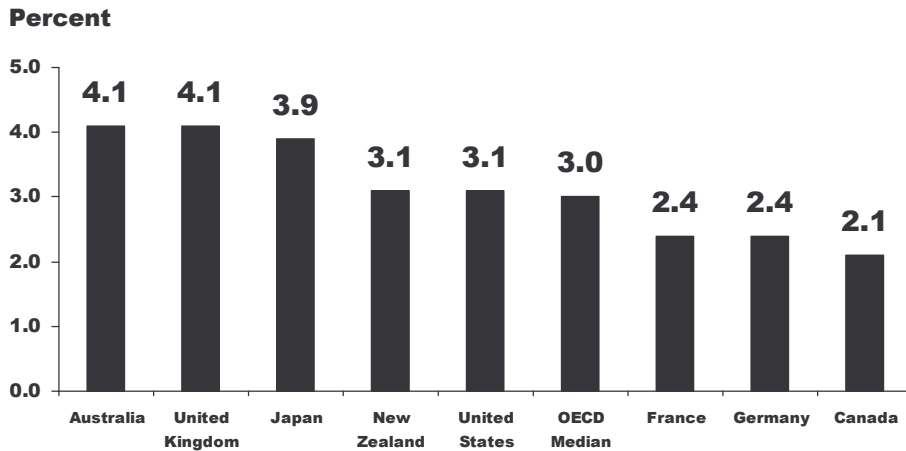
* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

Note: Income groups based on 2002 household income.

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



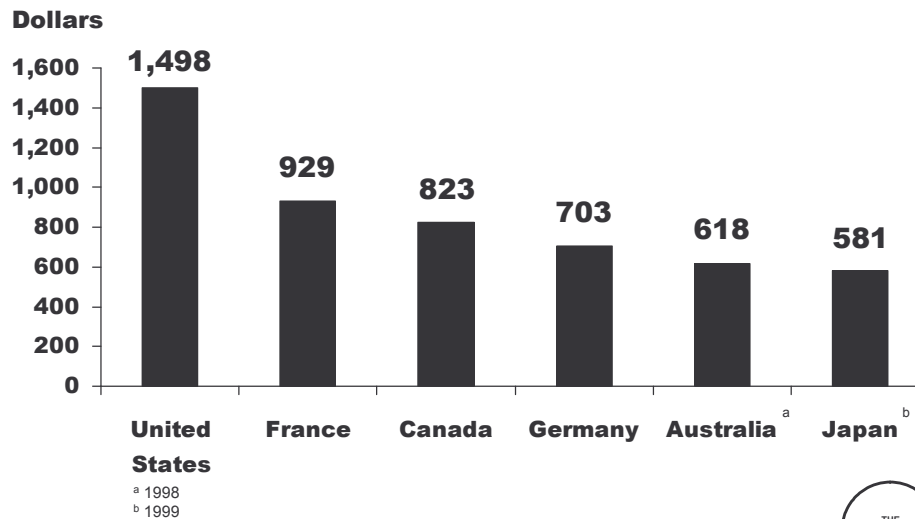
Average Annual Growth Rate of Total Health Care Spending per Capita Between 1991 and 2001 in Selected Countries



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



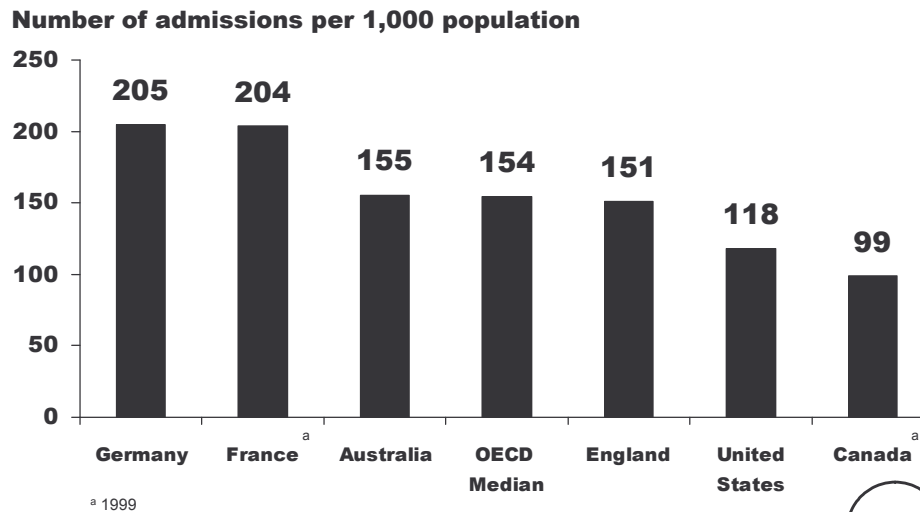
Hospital Spending per Capita in 2000 Adjusted for Differences in the Cost of Living



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



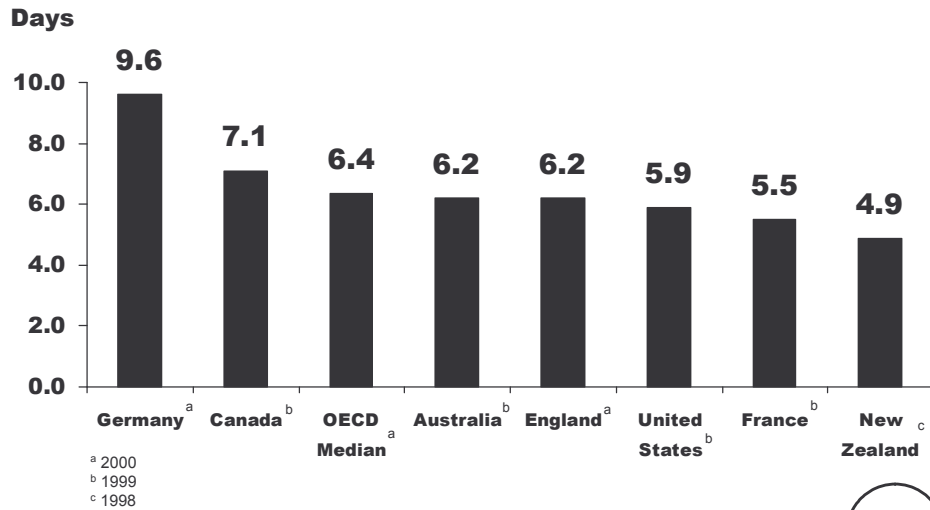
Hospital Admissions for Acute Care per 1,000 Population in 2000



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



Average Length of Hospital Stay for Acute Care

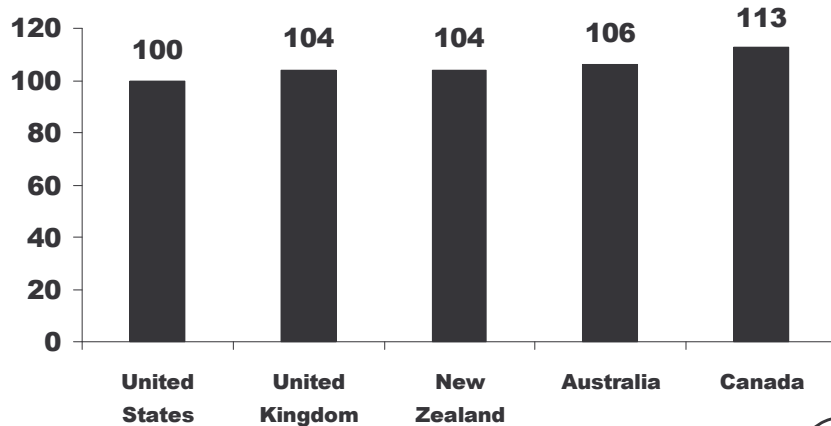


Source: G. Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002.



Kidney Transplant Five-Year Relative Survival Rate

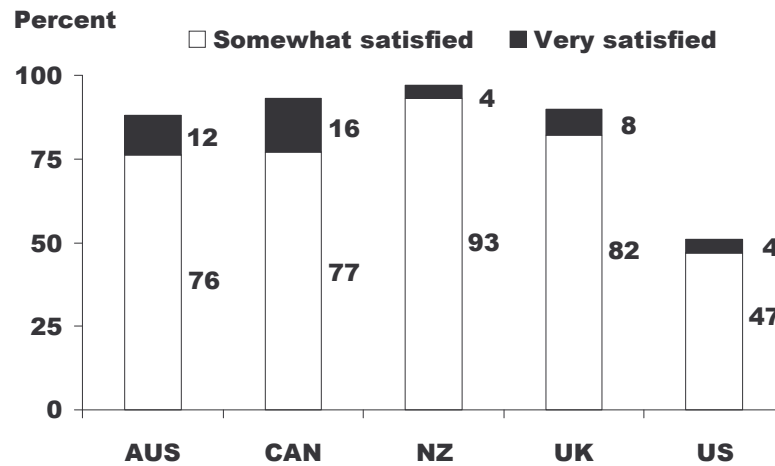
Standardized Performance on Quality Indicator
100=Worst Result; Higher Score=Better Results



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



Satisfaction with the Health Care System



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



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

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

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



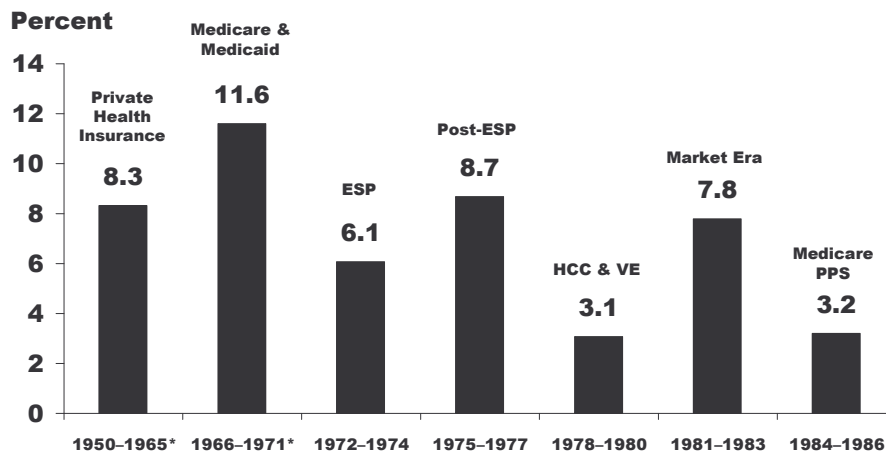
If You Had New Funding to Invest in a One-Time Capital Improvement to Improve Quality of Patient Care in One Area of Your Hospital, What Would it Be?

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



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

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



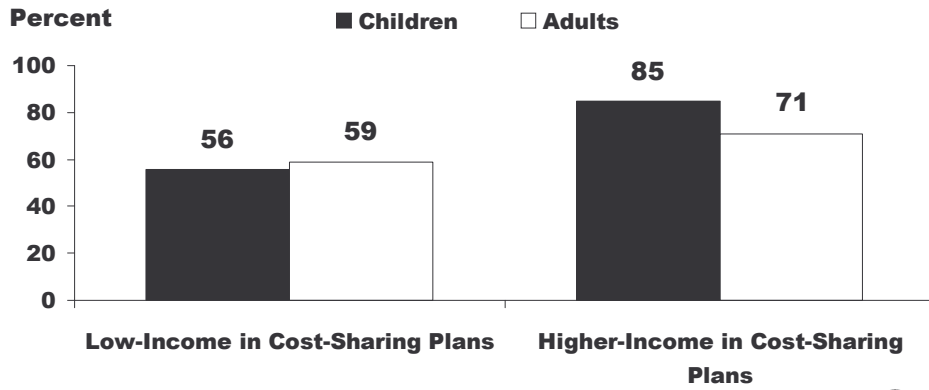
* Annualized.

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



Cost-Sharing Reduces Likelihood of Receiving Effective Medical Care

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

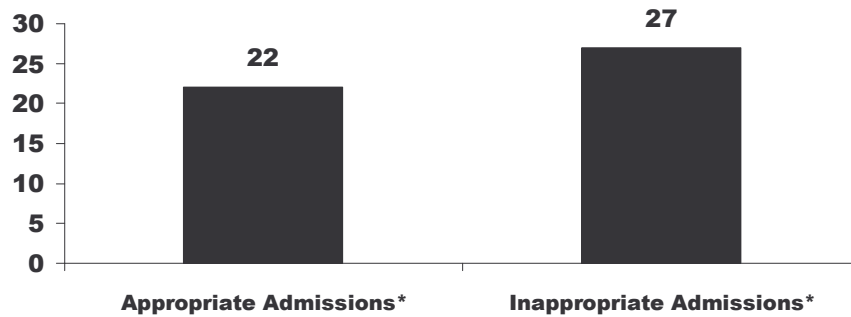


Source: K.N. Lohr et al., Use of Medical Care in the RAND HIE. *Medical Care* 24, supplement 9 (1986): S1-87.



Cost-Sharing Reduces Both Appropriate and Inappropriate Hospital Admissions

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



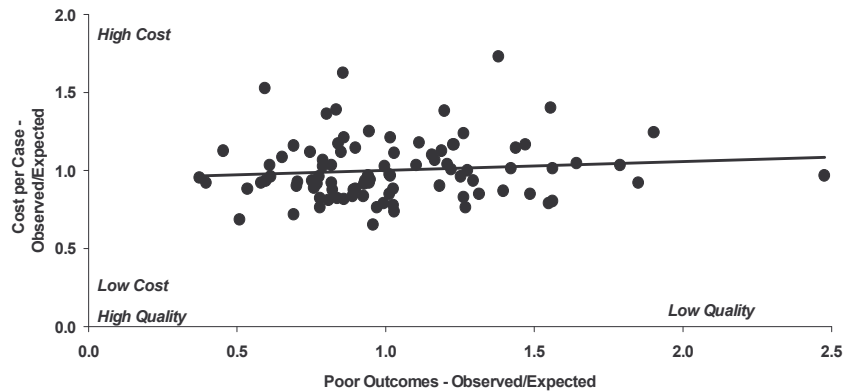
* Based on Appropriateness Evaluation Protocol (AEP) instrument developed by Boston University researchers in consultation with Massachusetts physicians

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



Cost and Quality Vary Widely Across Hospitals

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



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



Pay for Performance Programs

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

Source: Leapfrog report, draft for Commonwealth Fund.

