

## What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care

Keith T. Peters

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Health Law Commons](#)

---

### Recommended Citation

Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. Health Care L. & Pol'y 363 (2007).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol10/iss2/7>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact [smccarty@law.umaryland.edu](mailto:smccarty@law.umaryland.edu).

# WHAT HAVE WE HERE? THE NEED FOR TRANSPARENT PRICING AND QUALITY INFORMATION IN HEALTH CARE: CREATION OF AN SEC FOR HEALTH CARE

KEITH T. PETERS\*

## INTRODUCTION: WHAT HAVE WE HERE?

In his 2006 State of the Union address, President Bush declared, “[f]or all Americans, we must confront the rising cost of [health] care . . . and help people afford the insurance coverage they need.”<sup>1</sup> President Bush’s remarks are yesterday’s news; we all know the cost of health care is rising in America.<sup>2</sup> Rising costs may affect Americans through higher health insurance premiums, higher co-payments, and higher deductibles for those who have insurance.<sup>3</sup> Most of the uninsured cite the cost of insurance as the reason they do not have coverage.<sup>4</sup> Americans know generally that the problem is the rising cost of health care, but they currently have little information that would enable them to lower the cost of their health care. Americans know little about what their health care really costs until they have purchased it. They also have little information regarding outcomes

---

Copyright © 2007 by Keith T. Peters.

\* Associate, Cline, Williams, Wright, Johnson & Oldfather, L.L.P.; J.D., University of Nebraska—Lincoln College of Law (Lincoln, NE); B.A., Cedarville University (Cedarville, OH). Thank you to my beloved wife Karin for her love and unending support.

1. President’s Address Before a Joint Session of the Congress on the State of the Union, 42 WEEKLY COMP. PRES. DOC. 145, 150 (Jan. 31, 2006).

2. Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 537 (2006); HENRY J. KAISER FAMILY FOUND., KAISER PUBLIC OPINION SPOTLIGHT: THE PUBLIC ON HEALTH CARE COSTS (2005), available at [http://www.kff.org/spotlight/healthcosts/upload/Spotlight\\_December2005\\_HCC.pdf](http://www.kff.org/spotlight/healthcosts/upload/Spotlight_December2005_HCC.pdf) [hereinafter KAISER FAMILY FOUND.].

3. GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2006 ANNUAL SURVEY 25-37 (2006) [hereinafter EMPLOYER HEALTH BENEFITS], available at <http://www.kff.org/insurance/7527/upload/7527.pdf>.

4. See Jost, *supra* note 2, at 540-41 (inferring that the low income levels of most uninsured individuals prevent them from affording the comparatively high costs of insurance).

of procedures from various providers. If they could find the lowest price, they do not know whether that is the best value or whether they should spend more for a provider with better success rates. So what are Congress, doctors, hospitals, and insurance companies doing to communicate the cost and quality of health care to individual consumers so that they can make rational decisions regarding the location and quantity of the health care they are going to consume? And, even if consumers obtain this information, what can they do with it?

As my wife and I prepared to incur the first major medical expense of our marriage, the birth of our first child, we spent considerable time trying to determine how much the delivery and hospital stay would cost. We had insurance, but wondered how much out-of-pocket costs would be required to meet deductibles and co-payments. We encountered one transparent pricing system and one pricing system that was opaque to say the least. The doctor's office had transparent pricing; the business office told us the doctor's fee during our first visit. The hospital, on the other hand, did not have a clue. When my wife called the hospital business office to ask the total cost of a normal delivery, the woman in the business office stated that she did not know and had no list of typical charges. My wife then heard the business office person fumbling with the bills of other patients that were sitting on her desk. The business office person then replied that it was somewhere between the prices on two of the bills, but she could not be more specific—even though the range was several thousand dollars.

This article will consider the availability of pricing and quality information and what Congress should do to require and encourage its dissemination. In this Information Age, the ability to “have” information oftentimes separates success from failure. Although some scholars are skeptical,<sup>5</sup> this article assumes that pricing and quality information will affect health care decisions. This assumption is backed by a recent report prepared by the Federal Trade Commission and the Antitrust Division of the Department of Justice.<sup>6</sup>

As your grandmother may have told you, there are two kinds of people in this world, the “haves” and the “have-nots.”<sup>7</sup> Right now, almost all of us are “have-nots” as far as possessing the ability to access pricing and quality information. This article will argue that we all must become “haves” of transparent pricing and

---

5. Cara S. Lesser & Paul B. Ginsburg, *Strategies to Enhance Price and Quality Competition in Health Care: Lessons Learned from Tracking Local Markets*, 31 J. HEALTH POL. POL'Y & L. 557, 559-60 (2006).

6. FED. TRADE COMM'N & DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 35 (2004), available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

7. “As a grandmother of mine used to say, there are only two families in the world, the Haves and the Haven'ts . . . .” 2 MIGUEL DE CERVANTES SAAVEDRA, *THE INGENIOUS GENTLEMAN DON QUIXOTE OF LA MANCHA* ch. 20, at 141 (John Ormsby trans., Thomas Y. Crowell & Co. 1906).

quality information for successful health care reform to occur in this country.<sup>8</sup> In this article, transparent information means information that informs consumers of the actual cost and probable outcomes of a particular procedure. Transparent pricing information, if accompanied by information regarding quality, will enable Medicaid and Medicare recipients, individuals covered by insurance, and individuals without insurance to make better decisions regarding the quantity, location, quality, and types of services they consume.<sup>9</sup> Thus, Congress and the private sector should seek to place usable information regarding the price and outcomes of health care services in front of consumers.

In this article, I consider several of the solutions companies presently use to provide transparent pricing and quality information to their customers.<sup>10</sup> I conclude that although these solutions have started the flow of information, they are insufficient. To provide transparent pricing and quality information to all Americans, Congress must create an organization similar to the Securities and Exchange Commission (SEC) for health care—the Healthcare Provider Commission (HPC).

Part I of this article considers how providers<sup>11</sup> determine the price of health care. Subpart I.A considers how prices are determined and the factors that go into pricing on the national level. Subpart I.B considers how prices are determined at the hospital level. Part II considers solutions to the need for transparent pricing and quality information in health care. Subparts II.A and II.B review some of the current resources that are available to consumers with and without insurance, respectively. Part III addresses several criticisms leveled against the movement toward transparency. Because the present solutions do not go far enough to promote transparent information, in Part IV, I propose that Congress should create a Healthcare Provider Commission (HPC) with function and powers similar to the Securities and Exchange Commission (SEC). Subpart IV.A discusses how the HPC

---

8. One could argue that health care reform could be achieved without transparent pricing information if the federal government provided health insurance for all Americans. However, a government-run health care has been rejected in this country. See Paul Star, *What Happened to Health Care Reform?* 6 AM. PROPECT 20 (1995), available at <http://www.princeton.edu/~starr/20starr.html> (describing the collapse of health care reform during the Clinton administration). President Bush has strongly advocated for Health Savings Accounts and High Deductible Health Plans. See The White House, *Strengthening Health Care*, <http://www.whitehouse.gov/infocus/healthcare> (last visited Apr. 3, 2007). The need for transparent information is growing.

9. "A Dartmouth Medical Study suggested more medical care often leads to worse outcomes." Scott Milfred, *Great Care Needs Cost Injection*, WIS. STATE J., Feb. 26, 2006, at B3; Jost, *supra* note 2, at 597.

10. See *infra* Part II.

11. "Providers," in this article, refers to physicians and other health care professionals, hospitals, and facilities where an individual may receive health care. I have omitted pharmaceutical companies from most of my discussion, although many of the same principles could be applicable, in order to limit the scope of this article.

would function, some of the requirements and incentives it would provide, and the necessary partners from the private business community that would need to develop to provide transparent information. Subpart IV.B discusses the issues that will be raised by additional regulation in the health care market, and concludes that the HPC's regulation is worth the price. Finally, I conclude by summarizing the advantages of transparent information and the HPC.

#### I. HOW DO PROVIDERS DETERMINE THE COST OF HEALTH CARE?

Before addressing how transparency can benefit health care in the United States, it is useful to know how providers come up with the prices Americans are supposed to pay. The "price" of health care examined in this article can be divided into two prices. First, there is the list price of health care.<sup>12</sup> This is similar to the sticker price one might find when purchasing a new car—it serves only as a beginning point for the negotiations, for those who have the market share to negotiate.<sup>13</sup> In fact, in 2004, hospitals in the United States were paid about thirty-eight percent of their list prices by patients or their insurers.<sup>14</sup> From these list prices, private insurers, Medicaid and Medicare, and other groups negotiate discounts to arrive at what I will call the "actual price." Although the list price of health care varies widely across different regions of the country, the actual price paid is relatively static.<sup>15</sup> This article considers the price of health care on a nationwide scope in Subpart I.A and then considers the individual hospital's price in Subpart I.B.

##### A. *Pricing Nationally: The Method Behind the Madness*

The price of a particular provider's services depends on many factors including geography,<sup>16</sup> experience, location, government payment methods, and the desire to make a profit. Hospital prices are supposed to be determined by the cost of providing care. However, the reimbursement rates for federal programs such as Medicare and Medicaid drive the list price of health care.

Hospitals in the United States receive a large portion of their income from government payors such as Medicare and Medicaid. Medicare is a program sponsored by the federal government for people over 65, people under 65 with

---

12. See Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 57 (2006) (discussing the variations in calculating "list prices").

13. *Id.* at 59, 61 (discussing how hospitals negotiate individually with private insurers each year, resulting in discrepancies among actual prices paid for services).

14. *Id.* at 57 (omitting citation).

15. *Id.*

16. For example, Medicare payments vary by region. *Id.* at 60 (citing MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY app. A (2003)).

permanent disabilities, and people of all ages with kidney failure.<sup>17</sup> Hospitals in the United States receive about thirty-one percent of their income from Medicare,<sup>18</sup> and some hospitals receive as much as sixty-five percent from government payors.<sup>19</sup> A hospital must consider Medicare's reimbursement rate when calculating its list and actual prices for two reasons. First, Medicare's reimbursement rates do not typically cover the actual cost of providing health care to a hospital's patients.<sup>20</sup> In 2002, Medicare paid ninety-five percent of a hospital's actual costs for covered procedures.<sup>21</sup> With Medicare making up such a large percentage of a hospital's consumer base, for a hospital to turn a profit, it must make up its Medicare losses in other areas.<sup>22</sup> Thus, a hospital must establish a list price for health care, whereby it can still give discounts to private insurers yet make a profit from those payments, not to mention profit from payments by uninsured patients who may or may not negotiate a discount.<sup>23</sup> The practice of charging different amounts for the same services has been challenged in the courts, but upheld unless the price difference is egregious.<sup>24</sup>

The "lesser of cost-or-charges" (LCC) principle is the second reason that a hospital must consider Medicare's reimbursement formula when setting the price of health care.<sup>25</sup> The LCC principle means that a Medicare provider will be paid the

---

17. Centers for Medicare & Medicaid Services, Medicare Program-General Information, <http://www.cms.hhs.gov/MedicareGenInfo/> (last visited Apr. 4, 2007).

18. MEDICARE PAYMENT ADVISORY COMM'N, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM 64 (2004).

19. Uwe E. Reinhardt, *The Medicare World From Both Sides: A Conversation With Tom Scully*, 22 HEALTH AFF. 167, 169-70 (2003) (reporting transcript of interview with Tom Scully, administrator of the Centers for Medicare and Medicaid Services). Some physician specialties receive over eighty percent of their income from Medicare and Medicaid. *Id.* at 170.

20. Allen Dobson et al., *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications*, 25 HEALTH AFF. 22, 25 (2006).

21. *Id.*

22. *Id.* The authors note that "[i]f hospitals, on average, attempted to maintain margins of 4-6 percent in 2002, as they generally have done for the past two decades, they needed to make up for this nearly two-percentage-point reduction in total margin resulting from Medicare underpayment." *Id.*

23. A 2005 Kaiser Family Foundation study found that negotiation for the price of health care is on the rise, especially among the uninsured, twenty-four percent of whom report attempting to negotiate prices with their health care providers. KAISER FAMILY FOUND., *supra* note 2, at 21.

24. *E.g.*, *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1110-11 (1st Cir. 1989) (holding that a health insurer's negotiation of lower prices from health care providers does not violate the Sherman Act, "unless the prices are 'predatory' or below incremental cost—even if the insurer is assumed to have monopoly power in the relevant market"); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 518 F. Supp. 1100, 1106 (D. Conn. 1981) (finding that it was not illegal for Blue Cross to set limits on the amount it would reimburse pharmacies for certain prescription drugs, where it had not "conspired with its competition to restrain trade") (emphasis in original).

25. *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 108th Cong. 133 (2004)

lesser of its actual costs or its actual charges.<sup>26</sup> If a hospital decides to forgo payment for services from enough uninsured patients who are in dire need of life saving treatment, Medicare may find that the hospital's "actual charges" are to forgo payment and thus provide no reimbursement.<sup>27</sup> Thus, Medicare gives hospitals incentive to have high list prices and to collect those prices from insured and uninsured patients.

Medicaid presently accounts for seventeen percent of spending on health care in the United States.<sup>28</sup> Because Medicaid is a partnership between the federal government and individual state governments, reimbursement percentages vary by state.<sup>29</sup> Medicaid reimbursement percentages, on the whole, are not sufficient to cover costs incurred by hospitals providing care for Medicaid patients.<sup>30</sup> Nationwide, Medicaid payments leave eight percent of a hospital's costs uncovered.<sup>31</sup> Thus, hospitals must have high list prices and must collect a large percentage of those prices from private insurers or insured and uninsured patients.

Cost shifting by providers is the only way for our current system to provide medical treatment for the uninsured and patients covered by Medicare and Medicaid. A group of authors recently titled this phenomenon the "payment hydraulic."<sup>32</sup> The concept of the payment hydraulic is simply that as some pay less, others must pay more for the business to make a profit.<sup>33</sup> The payment hydraulic views hospitals as quasi-tax collectors, who "tax" the privately insured and uninsured through higher list prices to recover what hospitals cannot recover from the unfortunate, Medicare, or Medicaid.<sup>34</sup> This is not a traditional tax. But it is the mechanism by which the United States has socialized its health care system. Many who are opposed to a universal socialized scheme of paying for medicine still believe that hospitals should make price reductions for those who cannot afford it and that hospitals have a duty to provide charity care.<sup>35</sup> When hospital pricing and

---

(statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare & Medicaid Services), available at <http://energycommerce.house.gov/reparchives/108/Hearings/06242004hearing1299/Kuhn2104.htm>.

26. *Id.* at 134.

27. *Id.*

28. CTRS. FOR MEDICARE & MEDICAID SERVS., NAT'L HEALTH EXPENDITURE PROJECTIONS 2006-2016 tbl. 3, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>.

29. Reinhardt, *supra* note 12, at 61.

30. See Dobson et al., *supra* note 20, at 24 (describing the need to shift costs to "ensure [health] coverage for the under- and uninsured and, to a certain extent, to pay for social goods").

31. *Id.* at 25.

32. *Id.* at 23.

33. *Id.*

34. *Id.* at 30.

35. Tom Miller, Director of Health Policy Studies at the CATO Institute, proposed that the government should encourage individuals to be involved in paying for charity care through a tax credit:

collection policies became national news in 2004, Congress responded by holding hearings to determine whether it should make changes to non-profit hospitals' tax exemption.<sup>36</sup> There was even speculation that Representative Bill Thomas (R-Cal.) would require hospitals to justify their tax exemption<sup>37</sup> or risk losing it.<sup>38</sup> Some of the difference between Medicare and Medicaid reimbursement rates and the actual cost of care is likely recouped through increased efficiency,<sup>39</sup> but it is unlikely under our current system that everyone will pay the same price for the same care.

The payment hydraulic is another reason that private health insurance rates and overall health care spending have increased so sharply in the last few years.<sup>40</sup> The price of health insurance has increased because the plan bears the increased costs of its own pool of employees as well as a portion of the increase created by the uncompensated and under-compensated care pool.<sup>41</sup> As prices increase, fewer people can afford health insurance and the payment hydraulic forces up the cost of health care for those who can afford it.<sup>42</sup>

---

To bolster financing for charitable safety net care and ensure that it is delivered with private-sector efficiency, a new 100 percent, dollar-for-dollar federal income tax credit (above the line) should be provided for certain charitable contributions to provide health care services to the low-income uninsured. . . . The maximum individual credit amount allowed would be no greater than 10 percent of an individual's federal income tax liability in a given tax year. Eligible donations would have to be made to approved organizations that provide health insurance coverage, health care services, or payment of medical bills to uninsured individuals who are not eligible for optional federal health tax credits or Medicaid assistance. Organizations eligible to receive the donations must either be a non-profit, in accordance with Section 501(c)(3) of the Internal Revenue Code, or, in the case of health care providers and that who wish to receive direct donations, they must create a separate non-profit subsidiary to receive and distribute such funding. Eligible organizations could spend only as much of their donations as they could document were directed toward paying the health care expenses of qualified uninsured individuals. Taxpayers could designate the institution to which their donation would be directed, but they could not pinpoint the individual beneficiary.

*Rising Health Care Costs: The New Role for Consumer Empowerment, Greater Cost Medical Savings Accounts, and Two-Tiered Defined Contribution Health Plans Before the Wisconsin Assembly Comm. on Health, 2001 Leg., 95th Sess. 6 (Wis. 2002)* (statement of Tom Miller, Director, Health Policy Studies, The Cato Institute).

36. *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means, 108th Cong.* (2004).

37. Tax Exempt Hospitals Responsibility Act of 2006, H.R. 6420, 109th Cong. (2006).

38. *Id.*; Lorraine Woellert, *Making Hospitals Cry Uncle*, BUSINESSWEEK ONLINE, June 7, 2004, [http://www.businessweek.com/magazine/content/04\\_23/b3886118.htm](http://www.businessweek.com/magazine/content/04_23/b3886118.htm).

39. Dobson et al., *supra* note 20, at 25-26, 30.

40. *See id.* at 30 (noting that private insurance premiums are raised as a result of the "payment hydraulic"). Obviously, other factors, such as the underwriting cycle, also come into play.

41. *Id.*

42. *Id.*



The overall price of health care in the United States continues to rise.<sup>43</sup> Medicare and Medicaid reimbursement rates, and the care received but not paid for by the uninsured, continue to drive up the cost of health care.<sup>44</sup> Providers are forced by the payment hydraulic to raise the overall list price and thereby rates for the insured to make up the shortfall.

*B. Pricing at the Hospital Level—Have You Ever Heard of a Charge Master?*

The rationale behind the pricing of hospital care is even less clear when viewed at the hospital level. The method to a particular hospital's charges may be impossible to determine. One hospital's chief financial officer admitted, "[t]here is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set the charges."<sup>45</sup> Even if there is no standard method by which price is determined, there are still some common practices.

Most hospitals compile a list of full price or published charges into a "charge master."<sup>46</sup> A charge master is "a uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type."<sup>47</sup> Hospitals create the prices listed on the charge master by calculating the hospital's charge-to-cost ratio for a particular procedure and then raising or lowering prices to shift the cost of care to or from other procedures.<sup>48</sup> Prices listed on a charge master are affected by the payment hydraulic previously discussed.

Unfortunately, the solution to the lack of transparency is not as simple as requiring hospitals to make their charge masters public. Since 2004, California has required hospitals to make their charge masters available to the public and provide a copy to the Office of Statewide Health Planning and Development.<sup>49</sup> An individual may view a written or electronic copy of the hospital's charge master on the hospital's website or at the hospital's location.<sup>50</sup> Hospitals are required to post

---

43. See EMPLOYER HEALTH BENEFITS, *supra* note 3, at 18.

44. See *supra* notes 21 & 27 and accompanying text.

45. Reinhardt, *supra* note 12, at 57 (citing Lucette Lagnado, *California Hospitals Open Books, Showing Huge Price Differences*, WALL ST. J., Dec. 27, 2004, at A1).

46. George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 118 (2005-2006).

47. Payers' Bill of Rights, CAL. HEALTH & SAFETY CODE § 1339.51(b)(1) (West Supp. 2007).

48. INST. FOR HEALTH & SOCIO-ECON. POL'Y, THE SECOND ANNUAL IHSP HOSPITAL 200: HOSPITALS, BIG PHARMA, HMOS & THE HEALTH CARE WAR ECONOMY 38 (2004) available at <http://www.calnurses.org/research/pdfs/IHSP-Hospital-200.pdf>; see Leah Synder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 501 (2005).

49. CAL. HEALTH & SAFETY CODE §§ 1339.51, 1339.55.

50. *Id.* § 1339.51(a)(1).

notice at several locations within the building that the charge master is available.<sup>51</sup> California also requires hospitals to provide information about hospital quality and outcome studies done by The Joint Commission.<sup>52</sup>

California's requirement that hospitals must make their charge masters available to the public does not solve the real problem. Most charge masters are hundreds of pages long and include over thousands of items.<sup>53</sup> Items are listed according to their medical name and there does not appear to be any grouping or relationship whereby someone could determine the cost of a procedure.<sup>54</sup> Even if one could find the charge for the operating room and anesthesia, one would have no idea what other charges would be incurred during an emergency visit for a broken bone, let alone a complicated heart transplant. A patient or a family member of a patient would have little use for this mess, even if they had time to make an informed decision.

As of January 1, 2006, California requires hospitals to provide uninsured patients, upon request, a written estimate of the cost for hospital services that are reasonably expected to be provided based on the average length of stay and treatment provided for the patient's condition.<sup>55</sup> The hospital must also provide information regarding its financial assistance and charity care policies and even an application for charity care upon request.<sup>56</sup> California's most recent requirement takes a genuine step toward price transparency of medical care. Not only are the prices transparent, but the information is useful to the patient or patient's family member. California's legislation is the first real step taken by a government body toward useful transparent information.

## II. CONSUMERS CURRENTLY HAVE SOME SOLUTIONS BUT MORE ARE NEEDED

In almost every other area of an American's life, information about price, quality, and value is readily available. If someone is looking to buy a new refrigerator, car, or piece of electronic equipment, magazines such as *Consumer Reports* are available on the Internet<sup>57</sup> or at the public library. A financially conscious individual can seek stock and mutual fund information based on a wide

---

51. *Id.* § 1339.51(c).

52. *Id.* § 1339.51(d).

53. Laura B. Benko, *Price Check! Insurers Are Cluing Members in on What Doctors and Hospitals Charge*, MODERN HEALTHCARE, Nov. 14, 2005, at 48, 49; Reinhardt, *supra* note 12, at 58-59; *see, e.g.*, Office of Statewide Health Planning and Development, Healthcare Quality & Analysis Division, <http://oshpd.ca.gov/hqad/hospital/chargemaster/2005/chrgrmstrA.htm> (last visited Apr. 6, 2007).

54. CAL. HEALTH & SAFETY CODE § 1339.51(c).

55. *Id.* § 1339.585.

56. CAL. HEALTH & SAFETY CODE § 1339.58.

57. ConsumerReports.org, <http://www.consumerreports.org> (last visited Apr. 6, 2007).

variety of factors from companies like *Morningstar*.<sup>58</sup> Even the quality and value of local restaurants are readily available to someone with an interest, an Internet connection, or, if nothing else, a trip to the public library.<sup>59</sup> When it comes to information regarding the price and corresponding quality of health care, information is hard to find.<sup>60</sup> However, the traditional lack of transparency in the pricing of health care in the United States has recently begun to change.<sup>61</sup> Subpart II.A examines present and future solutions for those covered by insurance for the information vacuum. Subpart II.B examines present and future solutions for the uninsured.

#### A. *Solutions for the Insured: What the "Haves" Have*

There are two kinds of people in the health care market, the "haves" and the "have-nots."<sup>62</sup> For the purposes of this subpart, the "haves" are Americans who are able to obtain health insurance. The United States Census Bureau reports that more than eighty-four percent of the United States population, or about 245 million Americans, reported that they have health insurance.<sup>63</sup> Health insurance coverage is available to these individuals under a private or government plan for part or all of the previous year.<sup>64</sup> More than twenty-seven percent of the United States population has health insurance coverage through Medicaid, Medicare, or military care.<sup>65</sup> And this percentage is growing and will continue to grow as the population ages.<sup>66</sup> Among those who have health insurance, there are some, the "have-mores," who are covered by private health insurance. More than sixty percent of the total population obtains private health insurance coverage from their employers.<sup>67</sup> Americans who have health insurance generally have access to excellent medical

---

58. Morningstar, <http://www.morningstar.com> (last visited Apr. 6, 2007).

59. Some restaurant websites have information regarding prices, food reviews, and even online reservations. See, e.g., San Diego Restaurants.com, <http://www.sandiegorestaurants.com> (last visited Apr. 6, 2007).

60. *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 108th Cong. 53 (2004) (statement of Regina E. Herzlinger, Nancy R. McPherson Professor, Harvard Business School) [hereinafter Statement of Regina E. Herzlinger].

61. See, e.g., Benko, *supra* note 53, at 48.

62. DE CERVANTES SAAVEDRA, *supra* note 7, at 141.

63. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 16 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

64. *Id.*

65. *Id.* at 17. To clarify, twenty-seven percent of the entire United States population, or approximately 79 million Americans, are covered by Medicaid or Medicare. *Id.*

66. See *id.*

67. GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 7 (2005), available at <http://www.kff.org/insurance/7315/upload/7315.pdf>.

coverage and a third-party payor to defray the cost. Information provided to privately insured individuals is even more valuable as the number of Americans covered by private insurance is shrinking each year.<sup>68</sup>

Important to this article, Americans with private insurance coverage presently have more access to pricing and quality information than those who are unable to obtain health insurance or have coverage through Medicaid or Medicare. Thus, for the purpose of this subpart, I refer to the insured as those who are able to obtain private insurance and thereby have access to information provided by the insurance company. This subpart will provide several examples of pricing and quality information that private insurance companies are offering to their insureds.

### *1. Network Pricing*

Those that have insurance will quickly recognize this effort to help consumers understand price. In-network pricing encourages the insured to select physicians and hospitals that have pre-negotiated rates with the insurance company or self-insured employer.<sup>69</sup> These rates may be as much as fifty percent lower than the prices listed on the hospital's charge master.<sup>70</sup> The insured do not have the ability to see the lower rates themselves, but they know that they will have to pay the list price or significantly higher deductibles or co-payments to have a physical or stay in a hospital that is not within the network.<sup>71</sup> If price transparency is the goal, this is not the most drastic or complete step. It simply offers consumers one way to know how they can save themselves money on health care.

Some experts think that network pricing is the best way to save consumers money and communicate price variations.<sup>72</sup> They point out that current fee-for-service system of hospital pricing makes price information indecipherable to consumers, even if it is made available.<sup>73</sup> California's law that requires hospitals to publish their charge masters certainly supports this conclusion.<sup>74</sup> If the laws simply require providers to give access to incomprehensible information, consumers derive no benefit and providers likely incur greater costs.

---

68. DENAVAS-WALT ET AL., *supra* note 63, at 17.

69. Batchis, *supra* note 48, at 501.

70. Margarette Burnette, *10 Ways to Cut Health-Care Costs Before Treatment*, BANKRATE.COM, Dec. 4, 2006, [http://www.bankrate.com/brm/news/insurance/20061204\\_care\\_cost\\_health\\_a1.asp](http://www.bankrate.com/brm/news/insurance/20061204_care_cost_health_a1.asp).

71. See Christopher J. Gearon, *High Deductible, High Risk: 'Consumer-Directed' Plans a Health Gamble*, WASHINGTONPOST.COM, Oct. 18, 2005, [http://www.washingtonpost.com/wp-dyn/content/article/2005/10/17/AR2005101701285\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2005/10/17/AR2005101701285_pf.html).

72. E.g., *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 108th Cong. 19 (2004) (statement of Paul B. Ginsburg, President, Center for Studying Health System Change) [hereinafter Statement of Paul B. Ginsburg].

73. *Id.* at 20.

74. See *supra* Part I.B.

Not everyone is convinced, however, that the current system of network pricing is the best way to encourage lower prices and better care. Economists point out that network pricing discourages the type of competition that would improve value in health care through better outcomes.<sup>75</sup> They claim that network pricing encourages insurers to compete annually for subscribers instead of competing based on positive outcomes.<sup>76</sup> They also point out that network pricing gives deeper discounts to larger plans even though there is no cost savings for treating an employee of a large corporation over a self-employed individual.<sup>77</sup> Economists note that providers are competing for the “largest, most powerful group, able to offer a complete array of services” instead of seeking efficiency, and finally, that patients and insurers squabble over who is going to pay the bill.<sup>78</sup> The debate will continue, but the number of Americans with private insurance is declining.<sup>79</sup> Thus, the United States health care system needs more drastic change.

## *2. Information Provided by Insurers: The “Haves” Have Pricing Information*

While the spirited debate continues over the efficiency of the present network system and the wisdom of using third-party insurers or self-insured employers to negotiate and pay for a large portion of health care, some insurance companies have forged ahead to provide transparent pricing information to their insureds. Almost all of the programs which provide pricing information have begun since the second half of 2005. This information becomes more relevant to the insured the greater their coinsurance percentage.<sup>80</sup>

Blue Cross and Blue Shield plans in several states have begun to provide more transparent pricing information to their insureds. Blue Cross and Blue Shield of California, for example, does not provide transparent pricing information down to the last dollar, but rates each hospital based on overall costs. A hospital receives “\$” to “\$\$\$\$\$” to give patients an idea of how much they will need for that hospital’s services.<sup>81</sup> This solution pleases those who seek some pricing information as well as those who want to keep the current third-party payor system.

---

75. Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 67.

76. *Id.* at 68.

77. *Id.*

78. *Id.* at 69.

79. DENAVAS-WALT ET AL., *supra* note 63, at 17.

80. Statement of Paul B. Ginsburg, *supra* note 72, at 21.

81. *Id.* This rating system is limited, however, especially with regard to the likelihood that different hospitals will specialize in different procedures and therefore have higher costs for some procedures and lower costs for others. It is unlikely that any one hospital will always be the most or least expensive. See Guy Boulton, *Health Plan Lifts the Veil on Charges: List of Doctor, Hospital Prices is Most Extensive*

Blue Cross and Blue Shield of North Carolina provides retail price, or price before negotiated discounts, to customers through its website.<sup>82</sup> The information gives the low, high, and average cost an emergency room visit, an urgent care visit, an MRI in the hospital or at a doctor's office, a CT scan at the hospital or in the doctor's office, and a chest X-ray.<sup>83</sup> Disclaimers on the website clearly indicate that the information provided is merely an estimate of the cost of care without information regarding the specific locations. Thus, it is difficult to see how one would determine which hospital to visit until after receiving his or her bill.

In August 2005, Aetna became the first health insurance company to make actual pricing information available to its insureds on its website.<sup>84</sup> The website provides insureds with the actual discounted rates Aetna pays doctors for over twenty of the most common procedures that these doctors perform.<sup>85</sup> The information is only available to consumers in the Cincinnati, Ohio area and only covers 5,000 local physicians and specialists, so information regarding actual hospital or pharmaceutical pricing is not available.<sup>86</sup> Also, the information is not intended as a price comparison tool, as consumers are only allowed to look at one physician's pricing at a time.<sup>87</sup> Aetna's President, Ronald Williams, remarked that greater transparency in pricing and quality was needed "[t]o create a more functional healthcare marketplace. . . ."<sup>88</sup>

Aetna's decision brought criticism from several medical associations. The spokesman for the American Hospital Association remarked that Aetna's decision to make information available on its website caused problems for hospitals.<sup>89</sup> Another critic remarked that pricing information is not helpful because it

---

*Available*, MILWAUKEE J. SENTINEL, Feb. 23, 2006 (stating that even "the same procedure at the same hospital" can be priced differently depending on the health care plan).

82. Blue Cross & Blue Shield of N.C., <http://www.bcbsnc.com> (last visited Apr. 6, 2007). The Author was able to locate and view this information, even without receiving coverage from the health plan. Thus, this information is potentially available to uninsured consumers as well as health plan members.

83. Blue Cross & Blue Shield of N.C., Health Care Cost Estimator, <http://www.bcbsnc.com/apps/cost-estimator/cost-comparison.jsp> (last visited Apr. 6, 2007).

84. Benko, *supra* note 53, at 48.

85. *Id.* at 49.

86. *Id.*

87. *Id.*

88. *Id.* at 48. Regence Group and CIGNA Corp. have also started offering limited pricing information to their members in limited geographical areas. Regence's information provides a range of actual pricing information for a specific procedure at a particular hospital. *Id.* at 50. CIGNA's tool is designed to allow comparison shopping for medications at 52,000 pharmacies around the country. *Id.* at 49. One of CIGNA's Senior Vice Presidents commented on its program's goal: "Whereas members aren't likely to change physicians overnight, they can certainly choose to buy their Prozac at a lower-cost pharmacy, switch to a cheaper generic alternative or decide whether to get their flu shot at a MinuteClinic." *Id.* at 50.

89. *Id.* at 48.

“oversimplifies what is really a much more complicated process.”<sup>90</sup> Health care is different from a more straightforward purchase, such as buying a lawnmower, because “[a] lawnmower is what it is. But the human body is much more complex than that.”<sup>91</sup> The information provided by Aetna also does not provide other information which would explain why one doctor’s fees are higher than another if, for example, the doctor insisted on additional testing for the procedure.<sup>92</sup> Aetna has not indicated whether consumers used the information or whether the pilot program was successful. Some insurers have recognized the demand for pricing information among their customers and have addressed this demand to varying degrees. The success of these programs will likely determine whether they are expanded nationwide.

### 3. *Information Available from Employer-based Groups: The “Haves” Have Quality Information Too*

Pricing transparency makes up only half of the information consumers need to make good health care decisions. Insurance companies like Aetna are leading the way by providing transparent pricing information, but several other organizations have formed to provide transparent quality information. The Disclosure Project and The Leapfrog Group are two organizations that have focused on providing quality information. The Disclosure Project is an informal partnership of large employers, business coalitions, consumer advocacy groups, and labor organizations.<sup>93</sup> It also promotes the National Quality Forum’s<sup>94</sup> standards to define feasible standardized performance measures and ensure routine reporting by doctors.<sup>95</sup> Similarly, The Leapfrog Group<sup>96</sup> is a private, non-profit organization of more than 130 public and private employers and unions which provide over \$56 billion in health care benefits annually.<sup>97</sup> Members encourage their employees to seek medical care from

---

90. *Id.*

91. *Id.*

92. *Id.* at 50.

93. *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 108th Cong. 26 (2004) (statement of Peter V. Lee, President and CEO, Pacific Business Group on Health, San Francisco, California) [hereinafter Statement of Peter V. Lee]. The Disclosure Project includes “AARP, General Motors, Motorola, the Pacific Business Group on Health, the AFL-CIO, the Employer Health Care Alliance Cooperative (“The Alliance”) in Madison, WI, the American Benefits Council, and the National Partnership for Women and Families.” *Id.*

94. National Quality Forum, <http://www.qualityforum.org> (last visited Apr. 6, 2007).

95. Statement of Peter V. Lee, *supra* note 93, at 26.

96. The Leapfrog Group, <http://www.leapfroggroup.org> (last visited Apr. 6, 2007). Much of The Leapfrog Group’s information is also available to uninsured individuals. However, since the Group’s information is designed for customers with insurance, it is discussed in this subpart.

97. Statement of Peter V. Lee, *supra* note 93, at 26.

providers who excel in several safety categories.<sup>98</sup> The safety and quality information provided by The Leapfrog Group is organized in a format similar to that which one might find in *Consumer Reports*.<sup>99</sup> Each hospital is rated based on a predetermined standard list of factors.<sup>100</sup> The Leapfrog Group provides rates based on several categories and assigns the providers an overall ranking.<sup>101</sup>

Thus, the “haves” currently have both pricing and quality information available. However, it does not appear that any company has integrated this information for its customers in a format that would provide an overall recommendation. Consumers who are hungry for information must keep in mind that only recently have they become more involved in paying for a larger share of health care. This responsibility has created a desire for more information and more information will certainly come when there is a demand for it.

*B. Solutions for the Uninsured: Do the “Have-nots” Have Nothing?*

The number of Americans without private health insurance is growing. The number of Americans who have private insurance decreased in recent years, from 68.6 percent in 2003 to 68.1 percent in 2004.<sup>102</sup> In 2004, 15.7 percent of the population, or 45.8 million Americans, were without any health insurance coverage; meaning that they did not have coverage at any time during the year.<sup>103</sup> The 2004 statistics showed that the number of uninsured increased by 800,000 from the number with that status in 2003.<sup>104</sup> This subpart groups those without insurance and without private insurance as “uninsured” and looks at the many places where the uninsured may obtain price information or relief from the list prices of health care services. The insured may also benefit from the resources identified in this subpart, as they may use any of the resources available to the uninsured or may not always have the coverage they now enjoy.

---

98. *Id.*

99. Compare The Leapfrog Group, Welcome to the Leapfrog Hospital Quality and Safety Survey Results, <http://www.leapfroggroup.org/cp> (last visited Apr. 6, 2007) with ConsumerReports.org, *supra* note 57.

100. The Leapfrog Group, What Does Leapfrog Ask Hospitals?, [http://www.leapfroggroup.org/for\\_consumers/hospitals\\_asked\\_what](http://www.leapfroggroup.org/for_consumers/hospitals_asked_what) (last visited Apr. 19, 2007).

101. The Leapfrog Group, Understanding Leapfrog’s Hospital Information, [http://www.leapfroggroup.org/for\\_consumers/understanding\\_information](http://www.leapfroggroup.org/for_consumers/understanding_information) (last visited Apr. 19, 2007).

102. DENAVAS-WALT ET AL., *supra* note 63, at 17, 19 fig.6.

103. *Id.* at 16.

104. *Id.* Minorities are more likely to be uninsured. In 2004, 19.7 percent of Blacks, 16.8 percent of Asians, and 32.7 percent of Hispanics were uninsured, compared to 11.3 percent of non-Hispanic Whites. *Id.* at 17.



1. *Price Information for the Uninsured: Look-Not, Have Not*

A consumer does not need a high paying job with an excellent benefits package to have access to pricing information. However, the information that is available to the uninsured is much narrower than that provided to those with insurance coverage, as examined above.<sup>105</sup> The uninsured should seek out information before a medical emergency. They might be surprised of all that is available.

One source for pricing information is HealthAllies. HealthAllies was founded in 1999 by Andy Slavitt, an entrepreneurial graduate of the Wharton and Harvard Business Schools with experience in health care management.<sup>106</sup> Slavitt founded HealthAllies after a friend's wife, whose husband had died of cancer, came to him for advice on how to understand her late husband's medical bills.<sup>107</sup> Slavitt created HealthAllies for uninsured and underinsured consumers to provide pricing information along with other factors such as experience and location.<sup>108</sup> HealthAllies offers discounts typically available to those covered by large, private insurance as well as a single bill for all services provided, instead of multiple bills for every service received.<sup>109</sup> HealthAllies' website also provides links to additional information regarding providers.<sup>110</sup>

HealthAllies allows consumers to search for providers by location, experience at the procedure for which the consumer is seeking treatment, and the type of facility—public, private, or teaching/research.<sup>111</sup> Often, a consumer will receive a price quote from the same provider where (s)he would have sought treatment anyway, but at a much reduced price.<sup>112</sup> United Healthcare recently purchased HealthAllies and makes its services available for \$500 to \$3,000 per year depending on the consumer's location and desired level of service.<sup>113</sup> This service is obviously not free to the uninsured, but it does provide cost savings for a family who expects

---

105. See *supra* Part II.A.

106. Health Allies, About Us, <http://www.healthallies.com/public/about/> (last visited Apr. 11, 2007); Statement of Regina E. Herzlinger, *supra* note 60, at 65.

107. Statement of Regina E. Herzlinger, *supra* note 60, at 65; see also Regina E. Herzlinger & Michael Sherman, Health Allies Case Study, at 2 (Harv. Bus. Sch., Case Study No. 9-302-019, Rev. Aug. 2006).

108. Statement of Regina E. Herzlinger, *supra* note 60, at 65.

109. *Id.*

110. *Id.* Health Care Navigator, <http://www.healthcarenavigator.co.uk> (last visited Apr. 11, 2007), and Medical Care Direct, <http://www.medicalcaredirect.co.uk> (last visited Apr. 11, 2007), offer services similar to HealthAllies' to customers in the United Kingdom who do not want to use the government's health care system.

111. Statement of Regina E. Herzlinger, *supra* note 60, at 66.

112. *Id.*

113. *Id.*; HealthAllies, About Us, <http://www.healthallies.com/public/about/> (last visited Apr. 11, 2007).

to have some medical expenses each year. For many that are uninsured because they do not think they can afford the cost of care, this service may seem out of reach.<sup>114</sup> These people should not lose hope; there are other solutions discussed in Subpart II.B.2.

Companies are also beginning to provide solutions for more simple procedures. Not all of us will undergo a major operation during our lifetime, but nearly every parent will have to take a sick or injured child for emergency treatment. MinuteClinic was founded in 2000 by a father who took his son to an emergency clinic on a weekend for a strep-throat test.<sup>115</sup> After waiting for two hours, the father decided to open MinuteClinic urgent care facilities to provide faster care.<sup>116</sup> MinuteClinics are staffed by nurse practitioners, cost less than a trip to the emergency room, and are often located in retail stores, such as Target or CVS.<sup>117</sup> Customers can find the nearest location and pricing information for over thirty-five procedures on the company's website, and pricing information is clearly posted at each location.<sup>118</sup> A MinuteClinic patient typically pays cash for his or her services, but insurers have recently begun to include MinuteClinic as a covered provider.<sup>119</sup>

HealthAllies and MinuteClinic are complimentary solutions for an uninsured's medical needs. HealthAllies provides coverage for intensive treatment and MinuteClinic helps out with the day-to-day bumps and bruises. These solutions illustrate how creative companies will compete for the uninsured's medical dollars.

## 2. *Relief from the List Price of Health Care: Ask and You May Receive?*

The now-informed, uninsured patient still needs some tools to cope with the high cost of health care. This subpart looks at several mechanisms for the uninsured to lower the hospital's bill from its list price. Not all of these options may be one's first choice. Thus, I have listed them in order, from those which I find most palatable, to those which I find least palatable.

The first tool in the uninsured's toolbox is good ole' fashioned negotiation. After a consumer is armed with the knowledge that a hospital typically receives

---

114. A recent study by the Kaiser Family Foundation found that seventy-seven percent of the uninsured did not have insurance coverage because they could not afford it or they were uninsurable. KAISER FAMILY FOUND., *supra* note 2, at 18.

115. Minute Clinic, About MinuteClinic, <http://208.42.165.19/en/USA/About/> (last visited Apr. 11, 2007).

116. *Id.*

117. Benko, *supra* note 53, at 50.

118. *See, e.g.*, Minute Clinic, Treatment and Cost at MinuteClinic, <http://208.42.165.19/en/USA/Treatment-and-Cost.aspx> (last visited Apr. 11, 2007) (providing pricing information for treatments in various locations throughout the United States).

119. Benko, *supra* note 53, at 50.

thirty-eight percent of the list price for the procedure,<sup>120</sup> one may be able to find a “bargain” or at least pay something closer to the actual cost. In 2005, a survey found that eleven percent of all patients have negotiated prices with their health care providers.<sup>121</sup> Among the uninsured, twenty-four percent of individuals sought to negotiate.<sup>122</sup> Hospital administrators are concerned by this trend:

If patients are truly self-payers or have a high deductible, they will call around. We have had this experience already where they will call each facility and then come back to us and say, ‘Well, the hospital in this town has this price. Are you willing to underbid them?’ It’s a difficult situation in trying to then figure out what you’re bidding against.<sup>123</sup>

Another hospital administrator expressed concern that “the negotiation process . . . may start occurring at the registration desk. What do you do in those situations? The patient has just bought a car and now they want to negotiate their appendectomy.”<sup>124</sup> The concern of hospital administrators should encourage the uninsured, they have nothing to lose from negotiation.

A second resource for uninsured Americans involves a plea to the underlying mission or tax preferred status of the hospital—charity care. There is no national standard by which hospitals are required to provide a certain amount or percentage of charity care.<sup>125</sup> Charity care guidelines vary by state and hospital from at or below 100 percent of the federal poverty level<sup>126</sup> to family incomes as high as 300 percent of the federal poverty level.<sup>127</sup> The Census Bureau recently estimated that 12.7 percent of the United States population is at or below the federal poverty threshold.<sup>128</sup> Thus, these individuals should seek charity care as a means of coping with the high cost of health care.

Even if one qualifies for charity care, only California requires that the hospital provide a patient who requests it with information which would indicate his or her

---

120. See *supra* note 14 and accompanying text.

121. KAISER FAMILY FOUND., *supra* note 2, at 21.

122. *Id.*

123. *CFOs Brace Themselves for Increased Price Negotiations—This Time, by Consumers*, HFM, Feb. 2006, at 28 (quoting Jeanna L. Adler, CPA, CFO, Wise Regional Health System, Decatur, Tex.).

124. *Id.* at 28-29 (quoting Jay S. Herron, CPA, Vice President of Finance and CFO, Christus Health, Tex. and La.).

125. *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 108th Cong. 16 (2004) (statement of Nancy Kane, Professor, Harvard School of Public Health) [hereinafter Statement of Nancy Kane].

126. In 2006, the federal poverty level for a family of four was \$20,000 per year for the lower 48 states, \$25,000 for Alaska, and \$23,000 for Hawaii. Annual Update of the HHS Poverty Guidelines, 71 Fed. Reg. 3848 (Jan. 24, 2006).

127. Statement of Nancy Kane, *supra* note 125, at 16.

128. DENAVAS-WALT ET AL., *supra* note 63, at 9.

eligibility.<sup>129</sup> In 2004, Congress examined the tax exemption given to non-profit hospitals<sup>130</sup> as to whether it was equivalent to charity care these hospitals provided.<sup>131</sup> Some research indicates that approximately one-third of hospitals received tax benefits that were greater than the charity care these hospitals provided.<sup>132</sup> The solution to this problem is further discussed in Part IV, but uninsured Americans ought to consider charity care as an option to the high list price of medical care. Knowledge of whether one qualifies for charity care may be most of the battle.

The third tool for the uninsured is litigation against providers who charge the uninsured more for health care. The plaintiffs, lead by none other than Richard Scruggs of the tobacco class action litigation of the 1990s, have sued non-profit hospitals claiming they were overcharged for services.<sup>133</sup> The plaintiffs' complaints have had little success and often succumb to the defendants' motion to dismiss.<sup>134</sup> Other plaintiffs have sued pharmaceutical companies with claims that they were overcharged for prescriptions.<sup>135</sup> The plaintiffs who sued the pharmaceutical industry have had success certifying their case as a class action.<sup>136</sup> One scholar even suggested several theories which plaintiffs could use against providers to force price change industry-wide.<sup>137</sup> This solution may provide better access to lower prices for all Americans without insurance; however, it will likely do little in the short term to help the average uninsured consumer.

The uninsured also have a fourth tool available to them: physicians who offer an initial consultation at a fixed price if the patient will provide immediate payment. One such service, CashDoctor, is available online.<sup>138</sup> This service is still in its infant stages and has only a few providers who are willing to provide a

---

129. CAL. HEALTH & SAFETY CODE § 1339.585 (West Supp. 2007).

130. 26 U.S.C. § 501(c)(3) (2000).

131. Three different committees held hearings during the summer of 2004. *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 108th Cong. (2004); *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 108th Cong. (2004); *Charity Oversight and Reform: Keeping Bad Things from Happening to Good Charities: Hearing Before the S. Comm. on Finance*, 108th Cong. (2004).

132. Statement of Nancy Kane, *supra* note 125, at 16.

133. Batchis, *supra* note 48, at 506.

134. *See, e.g., Amato v. UPMC*, 371 F. Supp. 2d 752, 753 (W.D. Pa. 2005) (dismissing the plaintiffs' complaint for failure to state a claim).

135. *E.g., In re Pharm. Indus. Average Wholesale Price Litig.*, 230 F.R.D. 61, 65 (D. Mass. 2005).

136. *In re Pharm. Indus. Average Wholesale Price Litig.*, 233 F.R.D. 229, 230 (D. Mass 2006) (granting partial certification to plaintiff's motion for class action). At the time of publication of this article, this case continues.

137. *See* Batchis, *supra* note 48, at 505-38.

138. CashDoctor, <http://www.cashdoctor.com> (last visited Apr. 11, 2007).

consultation at a fixed price.<sup>139</sup> However, it may catch on among uninsured that have some resources to cover the cost of health care as well as individuals covered by the high deductible health plans and Health Savings Accounts promoted by President Bush.<sup>140</sup>

A final tool for the uninsured, medical tourism, may lead consumers to find quality medical care and a vacation at the same time. Medical tourists from the United States seek care abroad at a fraction of the cost, while medical tourists from Canada and the United Kingdom seek care abroad because they are often frustrated by long waiting times and cannot afford a private physician.<sup>141</sup> Countries such as Cuba, Costa Rica, Hungary, India, Malaysia, South Africa, and Singapore, among others, actively promote medical tourism for a wide variety of procedures.<sup>142</sup> India has the largest and fastest growing program, offering everything from hip to heart surgery, at prices that are between seventy and ninety percent less than what the same procedures cost in the United States.<sup>143</sup> In 2003, more than 350,000 patients traveled abroad to seek care.<sup>144</sup> Foreign hospitals have started seeking international accreditation to lure safety-conscious American patients away from their usual physicians and surgeons.<sup>145</sup> Critics of medical tourism point out that an influx of patients from Western countries may make the price of this care too expensive for poor indigenous people. But others have pointed out that medical tourists who have money to pay bills for these services may subsidize care for the poorer domestic populations in the foreign countries offering these services.<sup>146</sup>

Time will tell whether any of these solutions gain a foothold with uninsured Americans seeking medical treatment. Depending on one's need and one's bravery, all of these options will likely provide Americans with excellent medical treatment at fair prices.

### III. PROBLEMS WITH THE PRESENT SOLUTIONS

As health care pricing information becomes more available in the coming years, many of the solutions will move from experimental stages to commonplace. Today, even those individuals who seek price transparency may question the safety and quality of health care provided in developing countries. If we look beyond the

---

139. *See id.*

140. The White House, *supra* note 8.

141. *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS, June 18, 2004, <http://www.cbc.ca/news/background/healthcare/medicaltourism.html>.

142. *Id.*

143. *Id.*

144. Olga Pierce, *Cashing in on Healthcare Trade*, UNITED PRESS INT'L, Mar. 13, 2006, [http://www.upi.com/Health\\_Business/Analysis/2006/03/12/analysis\\_cashing\\_in\\_on\\_healthcare\\_trade/](http://www.upi.com/Health_Business/Analysis/2006/03/12/analysis_cashing_in_on_healthcare_trade/).

145. *Id.*

146. *Id.*

concerns that might be raised on the face of the ideas above, three other problems may arise with the rise in transparency of health care. This part examines the validity of three common concerns regarding transparency identified by those in the health care industry.

First, almost all efforts to encourage the transparency of health care pricing information will only work for procedures where the patient has multiple options and time to evaluate his or her options to make an informed decision.<sup>147</sup> In cases where a patient is diagnosed with cancer and is evaluating treatment options, is pregnant and thinking of where to deliver her baby, or is in need of a knee-replacement surgery, the patient likely has enough time to use the information to choose the best doctor at the best price for the particular procedure. But all of the quality and pricing information in the world does not help the patient who has just had a heart attack and is on his or her way to the hospital. Quality and pricing information also does not help an individual make the decision of whether to go through with the particular treatment or whether to accept another alternative.<sup>148</sup>

Also, transparency in health care will only help for those decisions where people have choices. If the patient lives in a geographical area that is only served by one hospital or physician, knowing that the physician is the leader in his or her field is the not the reason the doctor treats the patient's needs. It may simply be that this particular physician is the closest. The patient must also have resources to utilize choices. An insured patient who needs a procedure which will cost tens of thousands of dollars may ignore pricing information because the costs will exceed his or her deductible either way.<sup>149</sup> An uninsured patient probably cannot afford the \$90,000 bill any more than he or she can afford the \$120,000 bill. Medicaid and Medicare recipients may not see out pricing information if part of the bill will be paid by the government. Thus, transparency information is likely only valuable to someone with the time, options, and financial incentives to use it.

Second, some say that price transparency will not work because health care does not work like other markets.<sup>150</sup> These people point out that consumers have no idea what health care costs, thus, they have nothing with which to compare. A recent *Wall Street Journal Online/HarrisInteractive Health Care Poll* found that few Americans have any idea what the actual price of health care should be.<sup>151</sup> For

---

147. Jost, *supra* note 2, at 581-82.

148. *Id.* at 582.

149. Statement of Paul B. Ginsburg, *supra* note 72, at 21.

150. See Statement of Regina E. Herzlinger, *supra* note 60, at 59 (describing how, in the eyes of many experts, the American public is completely ignorant about the most fundamental aspects of health care).

151. Bonnie Hughes, *Public Perceptions of Costs for Health Care Products and Services Differ Widely*, 3 WALL STREET J. ONLINE 1, 1 (2004), [http://www.harrisinteractive.com/news/newsletters/wshealthnews/WSJOnline\\_HI\\_Health-CarePoll2004vol3\\_iss13.pdf](http://www.harrisinteractive.com/news/newsletters/wshealthnews/WSJOnline_HI_Health-CarePoll2004vol3_iss13.pdf).

example, a survey found that Americans estimated the average cost for birth via C-Section at just over \$6,000 whereas the average actual cost is \$13,500.<sup>152</sup> However, Professor Regina Herzlinger of the Harvard Business School points out that people only obtain information that is pertinent to their everyday lives.<sup>153</sup> In market-driven areas of our society, consumers are not concerned with inner workings of the product, they merely want to know quality and outcome information.<sup>154</sup> Look at the average person's car, for example. It is unlikely, in many parts of the country, that one could describe many of the pieces that make up his or her automobile, but almost anyone could find a copy of *Consumer Reports* or *Motor Trend* and quickly become educated as to which cars are the most reliable or fun to drive.<sup>155</sup> This point rings true: why would someone know the cost of a C-Section unless they or someone close to them has or will need the procedure? This challenge should not discourage those seeking to obtain and provide transparency.

Finally, some argue that consumers are better off having their insurer negotiate lower prices from providers because of the many different factors which make up the particular medical treatment.<sup>156</sup> These experts argue that transparency will only lead to higher prices as providers find out each others' charges.<sup>157</sup> These experts assume that health care is an exception the market system that works for almost every other good or service in the United States. They may be correct. However, if the incentives to create a list price which has no relation to actual cost are removed or changed, hospitals will likely price their services in a manner that relates to cost. This does not mean that health care will be free from some cross-subsidization between those who can pay for treatment and those who cannot—the payment hydraulic cannot be demolished without a fully socialized system.<sup>158</sup> It is simply too much to dismiss an idea that has worked in every other area of the market.

#### IV. SOLUTIONS FROM THE FEDERAL GOVERNMENT: HEALTHCARE PROVIDER COMMISSION

As discussed in Part II, the private sector has developed several solutions to the opaque pricing and quality information in health care. These solutions are hopefully the beginning of wholesale change in the way health care providers determine prices. But these solutions are limited in scope by the amount of

---

152. *Id.* at 2 tbl.3.

153. Statement of Regina E. Herzlinger, *supra* note 60, at 59.

154. *Id.*

155. *See id.*

156. Statement of Paul B. Ginsburg, *supra* note 72, at 18-19.

157. *Id.* at 21.

158. *See supra* notes 30-31 and accompanying text.

information that providers are willing to release. Given the goals of President Bush's health care reform plans,<sup>159</sup> transparent pricing and quality information are vital to the success of consumers. President Bush's plan calls for reform that would allow "Americans . . . to choose their health care based on individual needs and preferences and easily obtain understandable information about the price and quality of the care they receive."<sup>160</sup> Will the ideas discussed in Part II be significant enough to accomplish the President's goals? Likely no. Without government regulation or encouragement, widespread pricing and quality information is unlikely to materialize. This part discusses the development of what I call a Healthcare Provider Commission (HPC), whose function and goals would be similar to the Securities and Exchange Commission (SEC) in the financial market. Subpart A will provide a broad overview of the HPC and Subpart B will discuss potential problems which an HPC could cause.

*A. Health Provider Commission: Creating a Have-Equally Market*

A Healthcare Provider Commission would allow the insured and uninsured to be "haves." Everyone would have access to information regarding the price and quality information as well as access to information regarding the provision of charity care. The idea of an SEC for health care is not a new one. Harvard Business professor Regina Herzlinger proposed the idea when she testified during the 2004 Congressional hearings.<sup>161</sup> The criticism that the transparency of complex information would be of no use has surfaced before in this country. Before President Franklin Roosevelt created the SEC in the 1930s, business leaders claimed that accounting could not accurately measure business performance and the cost of regulation would exceed the benefits.<sup>162</sup> Today, the SEC compels audited disclosures and the use of generally accepted accounting principles, requires firms to compile and release financial statements, and requires authorities to evaluate the worthiness of a security.<sup>163</sup> President Roosevelt designed the SEC to provide transparency, but cautioned that "[t]he Federal Government cannot and should not take any action that might be construed as approving or guaranteeing that . . . securities are sound . . ."<sup>164</sup> The SEC is merely an agency that requires businesses to tell the facts about their finances. The SEC cannot insure that every company

---

159. See *supra* note 1 and accompanying text.

160. Press Release, The White House, State of the Union: Affordable and Accessible Health Care (Jan. 31, 2006) (on file with author).

161. Statement of Regina E. Herzlinger, *supra* note 60, at 64-65.

162. *Id.* at 62; JOEL SELIGMAN, THE TRANSFORMATION OF WALL STREET 1-2 (1982).

163. Statement of Regina E. Herzlinger, *supra* note 60, at 62 (citing MICHAEL CHATFIELD, A HISTORY OF ACCOUNTING THOUGHT 32 (1997); SELIGMAN, *supra* note 162, at 41).

164. *Id.*



provides truthful information,<sup>165</sup> but it has enabled the average American to participate in the securities market.<sup>166</sup>

Like the SEC, the HPC would work with private organizations to provide transparent pricing. The HPC would allow Americans to view prices that are fair in light of the information available to everyone.<sup>167</sup> This would not eliminate the fact that Medicaid and Medicare would likely continue to receive a discount over third-party payors and private individuals.<sup>168</sup> Providers would also need to set prices at levels that would cover charity care.<sup>169</sup> However, both insured and uninsured Americans would understand the care for which they are paying. Instead of patients receiving list prices for health care services that bear no relation to the actual costs for services provided, the HPC would require providers to make coherent pricing information available. The fact that some hospitals provide more charity and discount care would be comparable to private companies who incorporate a social mission.<sup>170</sup>

The HPC would also work with private organizations to provide information regarding quality of outcomes.<sup>171</sup> Patients need to know objectively where the best treatment options are located and reward those facilities. Providers will have to seek out the best facilities and determine what new ideas or innovations have increased the patient's likelihood of recovery. Providers may initially argue that transparency of quality information would result in a few overcrowded hospitals or that hospitals would not be willing to take the sickest patients who are unlikely to recover.<sup>172</sup> However, practice has shown that arguments against transparency are untrue. In the late 1980s, New York State's commissioner of public health required data about risk adjusted death rates of open-heart surgeries performed by physicians and hospitals.<sup>173</sup> After three years of the program, the state had the lowest risk-adjusted mortality rates in the country.<sup>174</sup> Providers who received low

---

165. The collapse of Enron proved as much, but Congress found the solution in the Sarbanes-Oxley Act. Charles M. Elson & Christopher J. Gyves, *The Enron Failure and Corporate Governance Reform*, 38 WAKE FOREST L. REV. 855, 874 (2003) (indicating that Congress enacted Sarbanes-Oxley "at break-neck speed" following the fall of Enron).

166. Statement of Regina E. Herzlinger, *supra* note 60, at 63.

167. *Id.* at 64.

168. *See supra* notes 30-31 and accompanying text.

169. *See supra* notes 33-34 and accompanying text.

170. Ben & Jerry's ice cream company has a three-part mission addressing quality products, economic success, and social involvement. *See* Ben & Jerry's, Our Mission Statement, [http://www.benjerry.com/our\\_company/our\\_mission/index.cfm](http://www.benjerry.com/our_company/our_mission/index.cfm) (last visited Apr. 11, 2007).

171. Statement of Regina E. Herzlinger, *supra* note 60, at 65.

172. *Id.* at 64.

173. *Id.* (citing Edward L. Hannan et al., *The Decline in Coronary Artery Bypass Graft Surgery Mortality in New York State*, 273 JAMA 209 (1995); Stanley W. Dziuban, Jr. et al., *How a New York Cardiac Surgery Program Uses Outcome Data*, 58 ANNALS OF THORACIC SURGERY 1871 (1994)).

174. *Id.*

scores from the program worked with more successful providers to determine what procedures were most effective. The study also failed to show unwillingness among physicians to take patients at greater risk.<sup>175</sup>

Other reports have shown that sharing of quality information between providers improves the quality of patients' care. In 2001, Cincinnati Children's Hospital embarked on a quality improvement program with its cystic fibrosis patients.<sup>176</sup> The hospital disclosed to its patients and their families that its cystic fibrosis program did not perform well.<sup>177</sup> Surprisingly, few families left the program because the doctors had told them the truth and were willing to improve.<sup>178</sup> Cincinnati Children's Hospital's frank look at the quality of its program should be the model for other hospitals. If a provider offers a quality product and patients know where to find it, business will certainly follow.

The HPC would also establish requirements for charity care to lower income individuals. As previously discussed, there is presently no national standard and few state standards that require providers to offer charity care to individuals with incomes at or below the federal poverty level.<sup>179</sup> The HPC would also require hospitals to disclose the availability of charity care to patients who identify that they will have trouble paying for medical bills because of their income.<sup>180</sup> Finally, the HPC would require non-profit hospitals to provide a level of charity care equal to or greater than total public assistance that they receive.<sup>181</sup> This would include federal and state income, property, and sales tax exemptions, private donations and gifts, and research grants.<sup>182</sup> This could be done through a voucher system or by a statement of charity care provided.<sup>183</sup> Assuming that at least some of the 15.7 percent of Americans who are uninsured<sup>184</sup> are among the 12.7 percent of Americans below the federal poverty level,<sup>185</sup> an increase in the amount of charity care would help provide care to those who need it most. The HPC could also

---

175. *Id.*

176. Atul Gawande, *Annals of Medicine, The Bell Curve—What Happens When Patients Find Out How Good Their Doctors Really Are?*, THE NEW YORKER, Dec. 6, 2004, at 85.

177. *Id.* at 86.

178. *Id.*

179. *See supra* note 125 and accompanying text.

180. California's law provides a starting point. *See supra* note 55 and accompanying text.

181. *See supra* notes 33-35 and accompanying text.

182. Statement of Nancy Kane, *supra* note 125, at 73.

183. *Id.* at 73-74.

184. *See supra* note 103 and accompanying text. The number and percentage of uninsured in the United States is often used as political fodder, but I cannot find any studies which indicate whether the uninsured are also among the poorest of Americans. Assuming that a large percentage of the uninsured are also below the poverty threshold, greater provision of charity care would help political leaders understand what percentage of Americans are really without any health care coverage.

185. *See supra* note 128 and accompanying text.

encourage private hospitals to provide charity care through tax deductions. The HPC could grant a dollar for dollar or even a greater percentage for every dollar of charity care provided. These deductions would encourage private hospitals to increase the amount of charity care available.

In the case of either non-profit or for-profit providers, the HPC could create regulations which would encourage providers to give preventative treatment as well as emergency charity care. Some point out that the lack of preventive care is much more costly in the long run.<sup>186</sup> Some of the current concern over the plight of the uninsured revolves around the lack of an annual check-up or other preventive care. The HPC's regulation of charity care could create regulations or provide incentives that would encourage providers to give preventative as well as emergency charity care.

The HPC would be comprised of elements similar to the SEC. The HPC would require insurers and providers to register and disclose information relating to price, quality, and charity care.<sup>187</sup> The HPC would allow insurers and large providers to determine which information would best determine good performance in the industry. The HPC would then require an audit by independent professionals similar to the SEC's accountants.<sup>188</sup> Finally, the evaluation process would be primarily the responsibility of private firms. These firms would act as a *Morningstar* for health care and would develop, when the information becomes available, widespread assessments of health care outcomes.<sup>189</sup> The examples described in Part II of this article, of companies which have developed quality and pricing transparency information even without widespread disclosure, almost guarantees that greater disclosure will result in more user-friendly information.

Congress should form the HPC with powers and responsibilities similar to the SEC. The HPC would address the need for transparency of pricing and quality information. Although there will surely be resistance to this level of disclosure, history reveals that similar businesses resisted disclosure before President Roosevelt initiated the formation of the SEC.<sup>190</sup> The HPC's overall benefits would outweigh the burdens and risks that hospitals would face. The HPC would also require provision and disclosure of information regarding charity care. This would ensure non-profit hospitals are making a contribution to the community which relates to the benefits they receive. It would also encourage private hospitals to provide charity care, thereby increasing the amount of charity care available in the

---

186. Malcolm Gladwell, *Dept. of Medicine, The Moral-Hazard Myth: The Bad Idea Behind Our Failed Health-Care System*, THE NEW YORKER, Aug. 29, 2005, at 47.

187. Statement of Regina E. Herzlinger, *supra* note 60, at 65.

188. *Id.*

189. *Id.*

190. *Id.* at 62.

market. Increased availability of charity care would allow more of the uninsured to receive charity care and possibly relieve some of the burden on non-profit hospitals.

*B. Health Provider Commission: Problems with Additional Regulation*

The benefits of the HPC are not without costs. A 2004 study reported that health care is already one of the most heavily regulated industries in the United States economy.<sup>191</sup> The study used both “top-down” and “bottom-up” methods to analyze the total cost of regulation on the economy. A “top-down” approach looks at the cost of regulation in other industries and calculates the cost of regulation of regulation as a percentage of gross economic activity.<sup>192</sup> Using the “top-down” approach, health care regulation has an estimated annual cost of \$256 billion, with a range between \$28 billion and \$657 billion.<sup>193</sup> Large variation occurs because some industries are much more heavily regulated than others. The “bottom-up” approach looks at a broad range of health-related regulations from insurance, Food and Drug Administration regulations, and the medical tort system.<sup>194</sup> This approach estimates the total cost of regulation at \$339 billion and is thought to be more reliable than the former estimate.<sup>195</sup>

Although it is clear that some of the regulation in the health care industry is necessary and should not be dismissed, one may question the wisdom of adding further regulation through the HPC. But the benefits of more transparent pricing and quality information cannot be weighed simply in dollars spent or saved. The HPC would be designed to improve outcomes in the health care industry as well as make the system more efficient. Now, seventy years after its formation, we recognize that the SEC is vital for success in the financial markets and without it, the average investor could not safely own shares in public corporations.<sup>196</sup> If Congress would adopt an HPC, similar results would follow.

#### CONCLUSION

The United States must confront the rising cost of health care and the lack of information regarding quality of care. Whether you are an average American or the President, everyone understands that the cost of health care is rising. The cost of health care is determined largely by the reimbursement rates of government

---

191. Christopher J. Conover, *Health Care Regulation: A \$169 Billion Hidden Tax*, POL’Y ANALYSIS (CATO Inst. Wash. D.C.), Oct. 4, 2004, available at <http://www.cato.org/pubs/pas/pa527.pdf>.

192. *Id.* at 3.

193. *Id.* at 1.

194. *Id.* at 4.

195. *Id.* at 18-19.

196. See *supra* notes 162-166 and accompanying text.

programs such as Medicaid and Medicare, the cost of providing charity care, and the need to generate revenue from paying customers in order to subsidize the costs of care for those who cannot pay for it.<sup>197</sup> Without a single-payor, government run system, there is likely no way to get around this payment hydraulic.<sup>198</sup> The list prices that providers charge are likely much higher than providers' actual costs. In most states, the actual costs are either unknown to the general public or, where they are known, the information is indecipherable.

There are many solutions currently available for insured and uninsured consumers who seek transparent pricing and quality information.<sup>199</sup> However, those who have insurance also have access to more information and the solutions available to the uninsured may be less than ideal. Congress should intervene and create a Healthcare Provider Commission, which would operate and offer services similar to the Securities and Exchange Commission. An HPC would provide transparent pricing and quality information to all consumers, whether or not they have health insurance. As long as the first priority of health care is to improve the quality and efficiency of health care in America, more information will help the market solve some of the present health care crisis.

The rising cost of health care cannot be completely solved by HPC or greater transparency of pricing and outcomes. But as with any complicated national issue, smaller steps such as the HPC and greater transparency need to be a part of that solution. The market system should be permitted to address problems with the pricing and quality information of health care. The HPC will use mandatory reporting requirements for all hospitals, require charity care to be given at least in proportion to the tax incentives non-profit hospitals receive, and give for-profit providers greater incentives to make charity care part of the hospital's mission. The HPC would take a real step toward confronting the high costs of health care services,<sup>200</sup> both for the haves and the have-nots.

---

197. *See supra* Part I.A.

198. *Id.*

199. *See supra* Part II.

200. *See supra* note 1 and accompanying text.