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Beyond The $10 Aspirin:
How Well Does Our Hospital Financing System Work?
January 24, 2006

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ED HOWARD: I'm Ed Howard with the Alliance for Health Reform. Welcome to this program on hospital pricing. On behalf of our chairman J. Rockefeller and vice chairman Bill Frist and the rest of the board, we're very pleased to have you at this venue. We're here so that we could avoid the potential of being bumped by a committee on the senate side, since they are indeed in session. Those of you who follow that sort of thing I think know that. We're proud to have as our co-sponsor of today's program the distinguished health policy journal *Health Affairs*, you should subscribe. If you haven't gotten your free sample copy, which was available downstairs, you make sure you pick one up on the way out. It is essential to understanding fully the topic of today's briefing. Most of the material about which you will hear in the next hour and 45 minutes comes directly from the pages of the January/February issue of *Health Affairs*. Now, those of you who are in the room, you listen to radio in Washington, you have heard from one of our local jewelers, nobody pays retail for diamonds anymore, why should you, right? [Chuckles] Well, today we're going to explore who pays retail, who pays wholesale, who pays cost, who pays below cost, and what the impact of all of that is on the healthcare financing system. Just two concepts for those of us who are not economists to keep in mind, one is transparency, that is to say the ease with which you can figure

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out what the prices and the costs of what you're buying really are. And the second, that of cross-subsidies, the fact that different payers pay different prices, often motivated on the pricers side by things other than pure economic reasons, like perhaps caring for the uninsured in the case of hospitals. We're very pleased to have with us today the founding editor of *Health Affairs* and the Washington correspondent of *The New England Journal of Medicine*, John Iglehart.

JOHN IGLEHART: Thank you Ed and good afternoon. Those marketing lines I think would hold up very well, and I appreciate that. Thank you. We worked on this issue for more than a year. It was an interesting exercise. All the papers were peer reviewed externally and cleared that bar. All the papers we publish are, in fact, peer reviewed. I just wanted to acknowledge the support of Chip Kahn and the Federation of American Hospitals. There were other supporters of this issue, particularly on the payer's side. We always like to keep the providers and payers in balance. But Chip was really a driving force behind this issue, and I take my hat off to him because these hospital pricing issues are messy and complicated and don't always show hospitals in the best of light. But there are many culpable parties here, including public and private third party payers, government health policy in general and of course the hospital industry as well. So I thank you, Chip, for both your intellectual contribution and your support. That

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is all I'm going to say, but I appreciate you coming to listen to our speakers.

ED HOWARD: Thank you, John. Just a couple of logistic notes. The materials in your packets include biographic sketches that will fill in the very large blanks that I'm going to leave when I introduce the speakers. We have the KaiserNetwork.org webcasters with us today, and you'll be able to view that webcast at the very latest first thing in the morning, and sometimes they get it up by the end of the business day today, along with materials that duplicate what is in your packets. You will also find those on the Alliance web site and within a couple of days you will see a transcript that you can comb through for those exact quotes.

We have a lot of to get through. I ask you, just based on a couple of things I heard as we were getting ready to start, to turn your cell phones and your pagers to vibrate, as opposed to the strange ring that you have. And also to just remind you that at the appropriate time, you can wade through the humanity and get to one of the floor mics to ask a question or you can write it on the green card that you have in your packets and we'll collect it. And then before you leave, please fill out the blue evaluation form so that we can make these programs better for you in the future.

As I said, I'm not going to introduce our speakers with anything like the level of detail they deserve, and I'm going

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to do it all at once so that we can maximize the time that is reserved for actual content. We're going to start of with Uwe Reinhardt, who teaches economics and accounting at Princeton. He has graced a number of Alliance programs. I would characterize Uwe as displaying intellectual vigor and an inclination to contrarianism [misspelled] and an unwillingness to take himself or anybody else seriously. So we're looking forward to his remarks.

Mark Miller, on my far right, is the executive director of MedPAC, which advises congress on both payment and other issues with respect to Medicare. He has a wealth of health policy experience and health financing experience in places as disparate and important as CBO, OMB, and CMS. You haven't been to CRS yet, Mark. [Chuckles] Maybe next.

Chip Kahn, as John noted, is the president of the Federation of American Hospitals, so he certainly has a rooting interest in the topic we're discussing today. He has also done service on both the house side and the senate side. He has been around long enough that he's served in both the majority and the minority and always for Republicans.

And finally, we will hear from Caroline Steinberg, the vice president for trends analysis at the American Hospital Association. She has spent the last decade-and-a-half doing policy analysis and consulting before AHA with the Lewin Group, one of the most respected consultants around, including a stint

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where she did some important work on the community tracking studies. So we have a very distinguished group of speakers and we want you to hear from them without us getting in the way any further. So Uwe, will you lead us off, please?

UWE REINHARDT: Thank you very much, Ed. Thank you for inviting me, and thank you all for coming. I'm stunned at this turnout on so dry a topic as hospital pricing. [Laughter] I'll be speaking mainly off the paper on The Issue of Health Affairs, which you have. This grew out of a conference organized by Chip Kahn's Federation of American Hospitals and John Iglehart last summer. There were a variety of papers, this is the one on pricing.

What stunned me in writing this paper was it took me more time to get everything repeated three times because when people described to me, hospital executives and insurance executives, how hospitals are priced. The first time you won't believe it. You might begin to believe it the second time they tell you. And only the third time will you believe it. Over it all, is the so-called charge master, which is a list of some 20,000 distinct prices, at least in California that's the sample master charge you get. For instance, one of these, P-7658, could be a [inaudible], which is much preferred by patients to the model A because it's a lot cheaper. This is what one little snippet of something that was 400 pages looks like. That's the charge master. In California is the only

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state I know where they have to be made public, they are resident somewhere in the Department of Health, and you have to pay 10 bucks to get it. I wouldn't recommend it if you did, because if you did, you wouldn't know what to do with it. These charge masters are updated by every hospital on its own, in its own method. These charge masters are not comparable among hospitals. They don't use the same structure and nomenclature. As one guy was quoted in *The Wall Street Journal*, "There is no method to this madness. As we went through the years, we had these cockamamy formulas. We multiplied our costs and set our charges." And that's the chap who said it. Now these list prices, as I said, vary across hospitals. *The Wall Street Journal* actually looked at some of them, they must have bought them. I'll just pluck the first line. For a chest x-ray in California the charges vary from $1500 at doctors' to $120 at San Francisco General. Same procedure. Now Ed asked, "Who actually pays these charges?" Technically, charges are defined as a price paid by a drunken male billionaire [laughter] who doesn't give a damn and whose wife isn't around to straighten out the bastard. [Laughter] That is the CMS definition of charges. The uninsured often are billed these charges, but of course don't pay them, because they would literally have to sell themselves into slavery to pay just for an x-ray.

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So that's where we are on the charges. Now the interesting thing is that very few people pay these. Medicare, of course, pays DRGs and then it has outliers that are based somewhat on charges. They get billed charges and then there's a charge-to-cost ration and Medicare pays cost. Medicaid pays DRGs or *per diems*. The health plans pay negotiated *per diems* or discounts of these charge masters, and then the uninsured get billed charges or increasingly they are paid on a sliding scale, which means they are billed on that basis. Because we like, as a nation, to confuse the elderly, that's quite clear now after MMA, we enjoy this like football since it's a sport, therefor the elderly actually get a bill that has these charges on it, but of course they don't pay them, they pay just their cost share and Medicare pays DRGs. Why we do this to elderly, I have no idea. But the Chinese have actually a word for describing this and the word is "Me-Shu-Ga" and in plain English it means nuts. It's the only way to describe to anyone what we do with our hospital system. And all of that is secret to boot. No wonder I'd be ashamed to reveal it too. And so the question now arises, how do we adapt this system to consumer-directed healthcare. Now you may be for it or against it. You may not like the sun going up in the East either. But I think consumer-directed healthcare will spread, whether it be employment based or in the individual market. And then the question is, how do we account, how do we deal with this. Now

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consumer-directed healthcare is actually a euphemism. What it really just means is high-deductible policies coupled with health saving accounts that are tax favored. The idea here is to make healthcare actually cheaper for rich people than for poor people because of the progressive tax rate. No one seems to write about this, but as a nation we are about to declare that rich people should have cheaper healthcare than poor people. But given that as an aside, how would prices reveal themselves to the individual?

There are two kinds, there are the employment-based health savings accounts or consumer-directed healthcare, and there is the one in the free market. My point would be, if it's employment-based, it probably can be made to work because employers, with insurers, can make web sites available that give you some information on prices. I talk about that later. But the individual market is a jungle. Now the bulk of the policies so far seem to have been bought in the individual or small-group market, which is highly unorganized. You can go the ehealthinsurance.com and see what offerings you have. I made myself here a 35-year-old woman with three kids. She is actually a real person making $25,000. She is uninsured and this is what she would get here. For $162, a $10,000 deductible—all of these have very, very high deductible—$10,000 and you have more in your package. But when you face a $10,000 deductible, you need to know what hospitals cost. And this is

then what somebody like that would see in California. What is this lady to do with a list like this? And, again, you see this [inaudible], whatever that is and the prices vary. What is she to make of that? So there are some solutions. I proposed one in the paper, which is DRGs for all. That is, you use DRGs for every payer, using DRGs as a relative-value scale, and then you allow each hospital to set its own conversion factor so you have a market. And then those conversion factors would be published, they could be on an 800 number, they could be disseminated very easily. So that's this idea, which I lay out. And there are some nasty problems. The question is: would you continue to allow hospitals to price discriminate, or should they all charge the same conversion factor to every patient? That's the design issue. So price discrimination, you might not want to allow it. And then you won't have to worry about the uninsured. The alternative to that, which seems to be talked about and might emerge in the private sector, would be to have web sites that tell the insured, not what the individual prices are that insurers have negotiated with the providers, but rather a patient could input the condition that he/she goes in to the hospital for, coronary bypass, and that machine would tell the patient, in your neighborhood hospitals, this would be the amount of your cost share at these individual hospitals. That, in a way, is the

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most relevant information to patients, and if that could be made available, that would help considerably.

Now this is all in the beginning stage. The health insurance industry has consistently over-promised and under-performed in the last 20 years when it came to making information available. There was a big brouhaha about managed care and it was a complete dud what they made available on the web site. We shall see so that basically the ball is in the courts of the private insurance industry. Five years from now we can meet, and we can see whether they rose to a challenge that is absolutely essential when you want to have consumer-directed healthcare. Thank you. [Applause]

ED HOWARD: Now let's hear from Mark Miller.

MARK MILLER: Okay, I'm Medicare Payment Advisory Commission and I'm going to characterize some work that we've been doing over the last year or couple of years. I think the view of the Commission is that in inpatient PPS system is not functioning well. There are payment distortions, there are cross-subsidies, and there's no differentiation on the basis of quality. And some of these problems lead some hospitals to focus on certain types of services and certain types of patients. So I'm just going to run through, in 10 minutes or less, a couple of things that we've done over the last couple of years that sort of talk about these problems or these issues.

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The first is that we conducted a survey of hospital charging practices. We did this with the Lewin Group. And we found results that were very similar to the things that Uwe has said, as well as a couple of the other articles in the Health Affairs Edition. There does not seem to be a systematic relationship between cost and charges. There is not comprehensive reviews of these charge masters, and you can see why that would be the case. So if the cost of providing something is falling over time, it doesn't get adjusted accordingly. And the things that drive charging practices are overall inflation factors, the notion of trying to hit particular revenue targets, the mission of the hospital, competition from other hospitals, and then of course perception, just community perception of your various charges.

Another body of work that we did over the last couple of years led to a set of recommendations on pay-for-performance. And let me talk a little bit about this. The commissioners were distressed and unhappy that the Medicare payment systems really are monolithic; they pay the same thing for a provider regardless of what happens in terms of efficiency or in terms of quality in many instances. And so their concern here was that the payment systems don't promote quality, and in some instances, actually work against it. So the staff went through various measure sets and developed sets of policy design principles, and that let to a set of

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recommendations for many providers, including hospitals, that in 10 seconds or less, you take small a percentage of payments and you link that payment to the performance of some set of quality measures. I think the commission views that that percentage would increase over time and that the measures would evolve and improve over time, and also that the commission has the staff currently working on looking at measures of efficiency as well. Now I'm going to stop there on pay-for-performance. I know Chip is going to talk about it a bit, and the conversation may get to some more detail there.

Another thing we were asked to look at was specialty hospitals. We were mandated to do a study for the congress, which we finished in March of 2005. And a couple of things here, we were asked to look at how specialty hospitals perform and what there impacts are. And, again, in the interest of time, I'm not going to go through—I forgot I had a slide show. It's a good one too so far, don't you think. [Laughter] We're asked to think about specialty hospitals and instead of going through the actual results of the specialty hospital study, which I can, I have some slides on it if it comes up in question. Let me just tell you what questions we were asked to look at. We were asked to look at comparing the cost of specialty hospitals to community hospitals; the mix of patients, private, Medicare, Medicaid, that type of thing; we were also asked to look at the financial impact on community

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hospitals, as well as whether there's an impact on specialty hospitals in overall service utilization in a market. Actually to that last point, two members of my staff, Jeff Stensland and Ariel Winter, have a piece in the *Health Affairs* on that particular point, which I guess is why I'm here. The two things I want to focus on for the remainder of my time are these issues: Does selection occur? And as mandated or asked in the congressional mandate, should there be changes to the Medicare underlying inpatient PPS system, to the DRG payment system?

Okay, it's been assumed for years that there are DRGs that are more or less profitable systematically and that there are patients that are more or less profitable. And what we did, using 2002 claims and cost data, is we actually went through a fairly complex process of figuring out the average cost and payments for each DRG. We focus on three questions. Are some DRGs systematically more or less profitable? And the answer to that is yes. Surgical DRGs tend to be more profitable than medical DRGs. Certain classes of DRGs, like cardiac surgery, tend to be very profitable. Certain classes of DRGs, like pneumonia with complications and comorbidities, not so profitable. The second question is, are there patients who are systematically more or less profitable? And, again, intuitively everybody though this to be true. I'm at five minutes, I want you to know. So I'm moving through this fast

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here. Are patients systematically more or less profitable within a DRG? Once again, everybody intuitively knew this, but we quantified it, and you can see this systematically across DRGs, medial/surgical, families of DRGs, and also if you array the data by hospital type you see that it is systematically true across hospitals. The question at the end, do specialty hospitals engage in selection? The answer is yes, and it's two kinds. Cardiac hospitals tend to pick profitable types of DRGs like cardiac surgery, for example. Orthopedic and surgical specialty hospitals tend to get the less complex patient and therefor, are more profitable for that reason. There is also some patient selection in cardiac hospitals as well; it's just not as pronounced as it is in orthopedic and surgical. And I want to be clear here, just in terms of a little caveat that we're not making a judgment about how that selection occurs. If you talk to a specialty hospital they'll say, it occurs because we are designed to take certain types of patients. If you talk to the community hospital, they say no, physicians are actively sorting complex patients to community hospitals, and less complex patients to specialty hospitals. And I'll just leave that question for you to think about.

But the larger point, which I want to move on to, is that there are clear distortions in the payment system, and while we did this analysis thinking about specialty hospitals, it affects all hospitals and the playing field is not level.

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In a sense, a way to think about it is a hospital can profit without necessarily being efficient or at a level of efficiency that we might like it to be.

This led to a set of recommendation that we made which are very complex and arcane, and I won't grind you through them in excruciating detail, but I will characterize them for you. The first three, if this is organized correctly, the first three are aimed at improving the distortions across DRGs, and then the last one is adjusting for severity of patient within DRG. Let me just characterize the first three or all of them for you very quickly, and then we'll be just about done and I think I'll make my time limit.

Of the first three, one is aimed at moving from cost charge-based weights to cost-based weights. It's for many of the reasons that you've heard here from Uwe, from our survey, from the articles in the *Health Affairs* edition. Charges have moved away over time from representing cost. And so one of the things that we would like to see happen is to start basing the weights on cost. This is very arcane point, but also we think that the calculation of the weights should start first at the hospital level, and then be aggregated up to the national level. And this is an attempt to control for different hospital practices. Hospitals mark up things differently, they have different way that they organize the costs, they have different ways that they structure their services and care, and

this is an attempt to sort of try and control for those differences before you aggregate up to the national sets of weights. A third idea has to do with the outliers. This one is also complicated, but I think I can get it across to you. If you have threshold for outliers, high-cost DRGs tend to cross that threshold more frequently and generate outlier payments. Those payments are then in turn built back into the weight, so you can see that DRGs that are more likely to have outliers, their weights will change at a rate that is different that is different than DRGs that don't have as many outliers. So what we have is a fix that would adjust for that problem and keep the weights for the DRGs peculiar to the average cases in those DRGs. I'm sure I lost several of you on that, but we can talk about it on questioning. The last thing, which I think is relatively straight forward, is to adjust for severity within the DRG. And these concepts and the methods for doing it have been around for several years. Actually, these ideas in general have been around for several years.

So let me wrap up by saying the following things: We believe that these changes would create a better and more accurate inpatient PPS system, that the payments for each DRG would be more accurately tracked to expected cost. We think it would also level the playing field. Now, I want to say explicitly, that this would not put money in the system or take money out of the system, but it would redistribute the dollars

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that are there in the system. And, of course, that causes concern among certain types of people. The point I guess I would make is that the current distribution of payments is also unfair. If a hospital tends to take the less profitable cases, pneumonia or more complex cases, than the current system is not fair to those hospitals. So we think this, as coupled with some other changes that we've talked about in the commission, pay-for-performance, that type of thing, can bring more equity to the payment system. And that's it.

ED HOWARD: Thank you Mark. Chip?

CHIP KAHN: **W**hile you're getting me set, let me thank John Iglehart for his kind words at the beginning and for the opportunity that *Health Affairs* offered the federation and its other co-sponsors to develop an issue, which I hope you all will spend some time looking at, I think it really does cover the waterfront pretty well in terms of issues related to hospital payment. And let me get right into it and say that my grandfather taught me from a young age that you should always buy wholesale if you can, avoid buying retial. And in a sense, that's the story of hospital payment for almost all Americans and it results in a complex system of partly regulated prices, partly contractually arranged or negotiated prices, but that's what most of us experience in the hospital. We can argue about whether or not that's good system. It's a system that has generally worked, but it pays for treatments and procedures,

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not the quality of those treatments and procedures. In a sense, that's what gets us into this issue of pay-for-performance. I'm going to talk about pay-for-performance conceptually, a little bit about the railroad tracks for pay-for-performance that will be laid for Medicare if DRA passes in a few days, which I anticipate it will. Then I'll talk about some research that we did that's in your issue on pay-for-performance that looks at all hospitals in terms of what they're reporting regarding a few conditions, applies to methodologies of those, and then I'm going to conclude with some thoughts and observation about pay-for-performance and its possibilities and also its limitations that I think you, as policy makers, need to keep in mind as we sort of trudge forward.

First, pay-for-performance, in terms of its goals is motherhood and apple pie and I would argue, in some form, essential to moving hospital care and care in our system forward generally. We want to see improvement of care, from it we want to inform consumers so they can make better decisions, and we want to pay for the value of what we're receiving, as well as the fact that we received a hysterectomy or we received an appendectomy.

Now, the railroad tracks that have been laid out by DRA, I was dated because I kept putting DEFRA if those of you in the room DEFRA, I think that was 1984, it came after TEFRA.

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But I guess nowadays we leave off the "f" and just go straight with the "d". DRA lays out a plan and so this is going to be really important to you over the next year. First, as you know from the Medicare Modernization Act, hospitals already are invited to report certain measures or they lose 0.45%. As of October 1 of the year we're in now, if they don't begin reporting on 22 sort of plus measures, they'll lose 2%. So the invitation is very strong. In terms of reporting, sort of paying for reporting, or P for Rheumatology, and they'll be additional measures in '08. In terms of pay-for-performance, they'll be two forms that are envisioned by DRA. One, that hospitals will be penalized after October 1, 2008 if on certain DRGs their infections which are hospital-induced or result in a hospitalization. And two, and probably more important because it has a broader future, there will be a broad implementation by the secretary of HHS of pay-for-performance that may include quality, may include cost, may include efficiency measures.

What we did in our analysis, which I think should shed some light on the issues that you'll have to think about as the DRA policy is developed by CMS. We took a very broad data source that we have available to us now, basically the 17 measures that are being reported. Remember there's something called a Hospital Quality Alliance, which is a joint effort of the private sector, of payers, of consumers, of accreditors, of CMS, of the government, of HRQ, and they came up with a set of

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measures that were approved by something called the National Quality Forum, which puts sort of the gold seal on measures. Most hospitals are reported now because they want to get that 0.45%. So there is a tremendous data source that we have in terms of these measures. You can see for each of the three conditions, we take these measures and put them into different condition, heart attack, heart failure, and pneumonia, we can see we basically have thousands of hospitals reporting. There are some intricacies to how we work the data, but basically you've got somewhere between 2500 and 3500 hospitals participating in each of our area of conditions that we're going to look at. Now remember, we've got 17 measure that are being sort of forced into each of these conditions, and these measures are basically process measures. But the first part of our analysis was to broadly look at how hospitals did. And what we did was we divided hospitals in terms of their performance for each separate condition. So we looked heart attacks first and we see that rural hospitals are more likely to fall in the bottom 20-percent of behavior in terms of response to heart attacks on the measure, and I'll describe some of those measures in a minute. Measures like, did the person get an aspirin when they appeared with symptoms for a heart attack? Teaching hospitals tended to do very well. Unfortunately, the guys I work for, at least at this stage, need improvement. You find sort of the same kind of results on

heart failure. But when we get to pneumonia, we see that rural hospitals tend to do extremely well with a lot of rural hospitals in the top two deciles, in terms of complying with measures. And teaching hospitals tend to do not so well. I will talk more about this when I get to my caveats, or my observation about pay-for-performance. But this is an important thing to keep in mind, that just because a hospital does well in some areas of treatment of procedures, they may not do well in others. And that may happen after you apply pay-for-performance.

Now there are sort of two models of pay-for-performance that we looked at. One was the premier demonstration, which is a demonstration that CMS now is in the second year of, heading to the third year, and it’s a demonstration which includes 270 or so hospitals. For 33 measures, the 17 measures that we have are a subset of the 33, those hospitals are basically getting scored on the measure of production for these conditions, these three conditions, and if they’re in the upper two deciles, they get rewarded. If they’re in the bottom two deciles, they get penalized. In terms of MedPAC, and Mark alluded to it, MedPAC made a recommendation that a certain amount, between 1 and 2-percent of Medicare money be set aside and that hospitals be given a bonus payment based on their performance on a given set of measures.

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So what are sort of the results of these two methodologies? One, we see that the methodologies pretty much cover the results I showed you initially, that urban hospitals tend to do better. They did better in terms of production on the three measures. Here we have combined all the measures for our payment of bonuses or penalties. Teaching hospitals tend to do a little bit better because they do better on hearts. And you can see how other hospitals did. Now remember, we were only dealing with three conditions, which is only about 16-percent of all activity, so the numbers are fairly low because we're taking a very small amount of payment and redistributing it across hospitals. We see with MedPAC that you get larger amounts of redistribution because there are larger amounts of money. I'm going to get to a point in a second, which is that both of these payment methodologies are basically arbitrary. They're not like DRGs where there was an aggregation of costs based on costs spent on particular procedures and then all of those added together to come up with a final payment that relates cost for a procedure to that procedure. Here, we're taking measures and then we're aggregating the production on those measures and then we're assigning some kind of penalty or bonus based on the behavior of the hospitals. But the two, in a sense, are disconnected.

Now just to go real quickly, where do hospitals need to improve? Well, if we look at whether or not when someone

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appeared with a heart attack hospitals provided thrombolic medication, we see that the second decile is 80-percent and hospitals are behaving at 31-percent. They are in 21-percent compliance on a case-by-case basis. They've got a long way to go. There's a broad distribution of how well hospitals do on these measures. If you pick up my handouts, you can look at these and see some of these things are medical, some of them are really systematic, in terms of what hospitals need to do to turn around their production.

Now let me quickly, because I guess I probably have about 30 seconds, go through the major observation that I've had. First, we have a natural experiment underway right now with hospitals compare. We only have one full year, 2004, but we have reporting going on and if we were given a chance, we could see whether reporting alone, because there is some evidence from some research that reporting alone, if it's public reporting, can actually lead to hospitals changing their systems and improving their care. We're not going to get that opportunity though, because we're going to be into pay-for-performance probably before we get a chance to look and see whether or not reporting alone, the embarrassment of not providing or meeting certain standards, can get people to provide the right care. But we also need to note that right now we have primarily process measures, and even though mortality measures and other kinds of measures that we can

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think of as outcomes are coming soon, real outcomes measures are really pretty far off in the future. So we're pretty stuck with process measures, albeit it, process measures that basic blocking and tackling should be done at 100-percent by all hospitals.

In terms of the performance measures, as I said, we have performance metrics, even though they are processes primarily that are empirical, but the payment is arbitrary, one-percent for the top two deciles. What does that mean? It means there was a decision to give one-percent for the top two deciles. Performance rates for a single condition or treatment is not necessarily an indicator of overall quality. If you read my data, if you have pneumonia, you want to be in a rural hospital. If you're in Washington, you're pretty far away. But if you have a heart attack or other heart condition, you want to go to an urban teaching hospital. That will not necessarily change even with the application of pay-for-performance. So the information doesn't tell you everything.

Second-to-last, we can report on a number of measures, but it's burdensome and expensive and we really need to get to the electronic health record before we can have across-the-board sort of thorough reporting of general hospital performance.

And finally, we always run the danger, in all these kinds of reforms, of the tendency to play to the test, rather

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than to actually change your systems. I'm over. Let me end there with those observations.

ED HOWARD: That's terrific, thank you Chip. Now all of the questions that you've heard raised in the course of the last 30 minutes, Caroline Steinberg, may answer. [Laughter]

CAROLINE STEINBERG: First of all, let me just thank you for inviting me here to be on the panel today. I just wanted to start by sharing with you an important book on the behavioral theory underlying economics and regulation as it applies to the behavior of the U.S. healthcare system. So what is the wisdom between these pages that is equally applicable to parents and policy makers? It's quite simple. Behavior is about reinforcement and consistent limits. Simply put, what you get is a combination of what you reward, in this case, the healthcare payment system, and what you allow, which is the underlying regulatory structure. Unfortunately, we have problems on both ends. We have broken payment system, and we have an uneven application of regulation. So while we want a well-functioning system, what we actually have is a house of cards. The house of cards that I'm referring to is actually a quite complex construction of cross-subsidies. We've private payers there on the bottom that subsidizes underfunding for Medicare and Medicaid. We've got higher revenues relative to costs for elective cases that help to subsidize for emergent cases, and the list goes on. Way at the top of our house of

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cards, we have those services for which the system actually pays nothing at all. Services to the uninsured and ironically, the thing that we want to most out of our healthcare system, which is the standby capacity we expect to be there when we need it most.

So why does this system work at all? Well, first of all, not all rewards in the healthcare system are financial. People chose to go into healthcare because they have a commitment to helping people. Second, hospitals have a strong historical mission and a tradition of community service. The majority of hospitals today are owned by their communities, and these communities have expectations of behavior. They expect their hospitals to be there 24/7 to meet their healthcare needs. And then also we have a regulatory structure that is supposed to support the behavior we want. We have Stark and anti-kickback rules that mitigate the financial incentives at the level of the individual practitioner, and we also have [inaudible], which ensures that as long as you have an emergency department, that your doors will be open to all regardless of ability to pay.

Now I'd like to talk about two pressing issues which make this house of cards very unstable. First, the top layers of our house of cards are simply getting heavier and heavier. We now have nearly 46 million people with no health insurance, and that number has been growing every year. At the same time,

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we have declining support for public programs. Today Medicare pays $0.92 for every dollar a hospital spends actually caring for Medicare beneficiaries, while Medicaid pays about $0.90. This shortfall of payment relative to cost for Medicare, Medicaid, and indigent care together has grown to 50 billion dollars in 2004. Hospitals are struggling against this with how to fairly provide and price services to the uninsured in the face of a very rapidly growing need. Private insurance is eroding because fewer and fewer employers are willing to foot this bill on top of what it actually costs for the people they employ, which is actually quite a lot of money. This situation puts our house of cards at risk.

The second issue has to do with the bottom layer of our house of cards in the rapid emergence of physician-owned limited service hospitals. Under the self-referral business model, physicians refer patients to facilities they own. This is something that is precluded by the Stark laws in many settings because it represents a clear conflict on interest and because of a very strong base of research indicating that financial incentives actually do influence referral decisions. There was early research in non-hospital settings that indicating that physicians refer more frequently to things they own, and the more recent research in the hospital environment has found evidence of both patient steering and cherry picking. So what we see is that the physician-owned limited service

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hospitals are taking the best paid services out of the pulse of these hospitals. The private-paid patients, the elective cases, the least complex patients, and the most profitable services. This leads the full-service hospitals without the abilities to subsidize those services that are less well funded or not paid for at all. Thus the selection practices of physician-owned limited specialty hospitals undermine the stability of our systems as a whole. So if full-service hospitals have the same incentives, than why aren't they practicing these same behaviors? The reason is that full-service hospitals have only a limited ability to select their patients. A full-service hospital can chose its location, but if it has an ED, than its doors are still open to all patients regardless of ability to pay. A full-service hospital can employ physicians, but strict laws prevent them from paying for referrals. A full-service hospital can invest in certain services over others, but ultimately it has to be prepared to meet the needs of all the patients who walk through that emergency room door. Any hospital CEO will tell you that if you don't have the capacity to meet the needs of your community, the emergencies crowd out the electives, not the reverse. And then finally, physicians, not hospitals, make referral decisions.

Why physicians self-refer in the context on limited service hospitals is such a threat to this house of cards is

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that physicians not only have the financial incentives to steer patients, they have the ability. By circumventing both [inaudible], the majority of them do not have functional emergency departments, and Stark by claiming that what is really a hospital department is actually a whole hospital, they have the freedom to pick and chose their services and decide which patients go to their own hospital and which patients go to the hospital across the street. And the data suggests that that is exactly what they do. MedPAC, GAO, CMS, and other researches have all documented the physician-owned facilities chose only the most profitable services to offer and direct only the healthiest and well-insured patients to their own facilities. Also concerning, as I mentioned earlier, past research in other settings has found that patients of self-referring physicians get more services, a lot more service. This has been well-documented for ancillary services like lab and imaging, which many forget are all available within the limited service hospital model. So in allowing the physician-owned limited service hospital model to exist, we hope for competition on the basis of quality and efficiency, but that's not what we get. Instead, we get what we reward, because we have inconsistency in the regulatory structure. We get cherry picking, we get patient steering, and we get excess utilization. The only feasible solution to this problem is to ban self-referral to these facilities. Fixing the payment

system is neither doable, nor does it fix the problem. Sure, we can tinker with Medicare inpatient payment, but to fix this problem through payment system reform at a minimum, we would also have to cover the uninsured, raise the level of funding for Medicare and Medicaid, explicitly fund standby capacity, and improve payment accuracy for all patients for all payers. And even if we did all that, we would still be left with strong incentives for excess utilization. The problem of physician-owned limited service hospitals is a symptom of a healthcare system in need of an overhaul. As the inequities in payment increase in the absence of a level regulatory playing field, more and more participants are likely to simply opt out. This raises the question, can the social contract survive? I look forward to your questions.

ED HOWARD: Terrific, thank you very much Caroline. Two things, we got slides late. Some of you may not have gotten copies. We will have the final versions in the case of some revisions is our web site later on this afternoon, so you can check for that. Secondly, the size of the podium and the dais limits, as well as the time available limits, the number of formal speakers we can have. We have heard a lot about specialty hospitals, if there are folks who couldn't get onto the panel who represent specialty hospitals in the room, we'd be delighted to have them be at the microphones, as we would the rest of you. Now is the time for you to ask your

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questions. Keep them as brief as you can so we can get through as many as we can. If you have a written question, put it on the green card, hold it up and somebody will bring it up to us. We will go from there. I also would remind you as you have to leave between now and our termination time that you take a minute of two to fill out that evaluation before you go. I have a question that was submitted in advance that will get us started. I suspect that it was aimed at you Chip, although it doesn't say that. Should the rules that apply for for-profit hospitals be different from those for non-profits, the ones that are exempt from most taxes?

CHIP KAHN: No. [Laughter]

ED HOWARD: Yes, in the back? Please identify yourself and direct the question if you have one. Okay, I've got another question on a card. Actually it's to be fair one that I jotted down myself on this card. [Laughter] I cannot tell a lie. I want to quote the CEO of a large New England hospital whom I heard speak within the last couple of weeks who said that his state had an uncompensated care pool that was so generous and pegged to charges as opposed to costs, that he actually, by getting the percentage of his billings reimbursed by that pool, made money on uncompensated care. Now I wonder whether that is a result that the panelists consider plausible, desirable, common, or fictional.

CAROLINE STEINBERG: Now I've certainly never heard that complaint before, that we were being over-reimbursed.

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ED HOWARD: He wasn't complaining.

CAROLINE STEINBERG: I guess that isn't a complaint, [laughter] but that isn't something that I've been aware of.

ED HOWARD: Uwe?

UWE REINHARDT: Well it could be though if you count incremental costs only because the parking lots, the president's salary, the elevator, all of that would be paid for one way or the other. So an economist tends to think of incremental costs, so you have a patient who comes in who doesn't pay the bill. What did it actually cost you in bed sheets, food, supplies, to maybe some extra nursing time? But those incremental costs are actually quite low relative to fully allocated cost. So it could very well be that on a cash basis, he makes money off that pool. On an accounting basis, he probably wouldn't.

ED HOWARD: Anybody else?

CHIP KAHN: Let me add that I'm not going to defend the level of charges but at the end of the day, if there was such a pool, we can debate the appropriateness of the level of charges, but there's no reason that a hospital, if you had a pool, shouldn't make money, because you need to have a positive margin to keep yourself in business. So I'm not defending charges, but I'm saying the comment per se or that if everyone was insured so that money was paid for everyone, that hospitals wouldn't make a positive margin. It's very appropriate.

ED HOWARD: Yes, please.

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ERIN MCKILNE [misspelled?]: Hi, I'm Erin McKilne from the American Nurses Association and speaking about costs here I think is important, but I think another decision-making factor that's terribly important to patients, and certainly to consumers, is the quality of care. If you're somebody who's going in for open heart surgery, you might go ahead and sell your car if you believe you're going to a hospital that's not going to kill you. With that said, I have a question for Chip and anybody else who feels like jumping in about the commitment to reporting everything the NQF recommends should be reported, and specifically speaking to the setting *The Very Same Health Affairs* by Needleman and Berhaus talking about the relationship of nurse staffing to patient outcomes, specifically mortality.

CHIP KAHN: Well, the National Quality Forum considers a lot of measures. All of the measures are good, worthwhile. Should information on all of them be collected and reported? One, that wouldn't be physically possible, and financially it would just be impossible at this point. And second, I think we need more filters, and that's why the Hospital Quality Alliance acts as a filter to go through what the measures are that work now that are practicable and can brought on line. I think we have to be very careful with certain kinds of standards. I think that the Weinberg research, which basically blew up the *US New and World Report* study, which is based on indicators like the number of nurses needs to be paid attention to and that the level of certain factors may not be as important as what

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a hospital does. And I think that's where we're headed with this kind of quality evaluation.

MARK MILLER: Just a couple of other things, which are just to leap forward off of things that were said. When the commission went through its process of setting up or talking through how you should design a policy like this, one of the things they called for is the need for an entity that brings together all people involved here, payers, providers, government and private to do a few things and these address some of the concerns that I think Chip raised. One is to make sure that there is coordination between the public and private, so if pay-for-performance gets legs and starts moving, you don't have different sets of measures that you have to work through with each provider. Also, this forum would be generating new measures and doing analysis on the relationships of those measures. And so, for example, if the staffing ratios are one of them, than that would be reviewed. And then to review [inaudible] into the process as appropriate. A couple of other things, Chip said something about being worried about teaching to the test, which I think is a legitimate concern here, and this would also sort of bring measures on, retire measures, that type of thing. And I had one other thing to say about it, but I've forgotten it now, sorry about that.

ED HOWARD: If it comes back to you, let us know. Yes, go ahead.

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JIM HEIN [misspelled?]: Jim Hein, Congressional Research Service. I understand that this is a discussion about hospital financing, but so far I haven't heard anything about the discussion about vertical integration and the fact that the hospital is only part of the continuum of care. I wonder if you could talk about your suggestions of when you think about how to reform hospital payment, not only just hospitals, but look at how we pay hospitals relative to physicians relative to other parts of the healthcare system, and making sure that we're actually promoting efficiency rather than just shuffling around the money.

CAROLINE STEINBERG: I'll jump in on that one. One of the things when I was trying to think about what to do my presentation on, one of my early working titles was Hospital Payment Policy: Rewarding A, While Hoping For B. And I think this is a very good example of how we have a payment system that does not reward collaboration, and collaboration in ways that actually protect the interests of the patient, collaboration towards providing more efficient care, not more care, and care that is high-quality. And I think that MedPAC's recommendations around gain sharing and efforts in that direction to figure out ways that we can develop payment systems that make everybody work together as a team, I think is a major goal for the system.

MALE SPEAKER: I think you raised a very good point, and at least in terms of the quality reporting and measurement

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side that ultimately will feed into payment, there it really needs to be done together. If you look at most of the hospital measures, most of them relate to a physician order. Did the physician order the aspirin? Did the physician order the beta blocker? So working together is critical, and I think over time we've got to work, at least in terms of measurement reporting, to a single platform that ultimately would join the ambulatory side and the hospital side. However, at least in the near term, I find it hard to climb out of our silos simply because we didn't figure out how deal with the complexities of managed care, as Uwe sort of alluded to, and I think at least at this stage, each silo has got to clean up its act at least in the short run as best we can.

MARK MILLER: I think I'm going to say some things that work that same way. You come to something like this, they give you 10 minutes, but we have a lot of other things that are going on. For example, in the pay-for-performance work when we went through that, we had to make the very uncomfortable, but necessary decision to say, you know what? We're going to have to start with pay-for-performance within each of these area if we're every going to get anywhere and openly acknowledge that we were missing the fact that you can also gain quality through coordination. We have a different set of activities ongoing now in front of the commission, if fact, the first presentation on it was either at the January meeting or the December

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meeting, I've forgotten, on how to start promoting coordination of care between providers, mostly in this particular instance, between groups of physicians and between physicians and hospitals. So there it's the notion of can you look at the payment system and make changes that will bring people together and promote that coordination? So we have an agenda working along that line. The other thing that we talked about when we were in the realm of talking about pay-for-performance, is the notion of going through physician practice styles, organizing on the basis of episode, and looking at their practice of care and looking their resource use. Obviously how many visits, how many MRIs, that type of thing, but also how many admissions so that you're looking at, like Chip just said, both outside the hospital and inside the hospital. So we're driving towards those measures as well. You could, and this is ahead of the commission so I don't want to say this strongly, but the notion is could you move Medicare's payment system to that it differentiates on the basis of both the quality that you get and on the resources that went into getting it.

UWE REINHARDT: I think ultimately the answer everyone sort of dreams about in this regard is Kaiser, with its fully integrated, capitated, sophisticated management, et cetera. And it's amazing. Paula Elwood [misspelled?] wrote about that in 1971 and somehow we talk about it, but we just don't like it when we see it.

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MALE SPEAKER: I'm wondering, to follow up on the last question, whether all these stresses and strains on the general hospitals are really a reflection of the fact that maybe the traditional full-service general hospital is no longer the proper type of healthcare thing to provide our healthcare in the 21st century. We do have children's hospitals, we have psychiatric hospitals. You buy your Walkman not from a department store anymore; you buy it from a big box store. So maybe the problem is not so much with the payment systems as with the fact that maybe we need to revise our concept of what a general hospital should be to be something different than it was 100 years ago.

ED HOWARD: Yes, Caroline? You have an opinion about that? [Laughter]

CAROLINE STEINBERG: Yeah, I think we have to be careful how we structure this system because about 80-percent of all the costs of care are for the 20-percent of people who have multiple chronic conditions, and so whether specialization really contributes to fragmentation, whether we need fragmentation and specialization or integration I think is an open question given the needs of our population, which are more and more towards chronic diseases and very complex patient that need interdisciplinary care.

MALE SPEAKER: I would answer the question actually the opposite way and that is that the United States really in our healthcare system very rarely looks to other parts of the world and

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when we do, we always sort of focus on the coverage side and say, well everybody else has universal coverage. Well, actually that's not what I would argue, at least from a delivery side, is the biggest difference between us and the rest of the world. Almost the entire rest of the world has a German/British model in which all the specialists basically are employees of the hospital, and you only have your general practitioners outside the hospital. That way, in terms of anybody who's sick or seriously ill, it's forced. There's much more integration for their care. Now that can be breakdowns between that institution and the community where you've got your general practitioners, but I would argue that maybe we should look at that alternative rather than this kind of disaggregation that, in the way we finance our system, can only lead to more hyperinflation.

ED HOWARD: Okay, Mark and then Uwe.

MARK MILLER: What I would also say, and it's just to take maybe the step before your question, it may be that in certain marketplaces where you begin to see these stresses and strain most significantly, maybe it raises the question there, do all of the hospitals in that market need to remain? If changes occurred in the hospitals integrated, maybe the remaining hospitals could function more efficiently. So it's the question before, oh my God, should we just completely change what hospitals do and how we think about them? But you could be looking within a marketplace, looking at those stresses and saying look, should all of these be in the game?

ED HOWARD: Uwe?

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UWE REINHARDT: I think it makes some sense to have some specialty hospitals for a few things, but this idea of a whole system of focused factories where you dismantle the hospitals into these focused factories, I once had a dream where that happened and then some young kid at Goldman Saks figured out if you consolidated all these focused factories, look at the overhead you would save. [Laughter] And so on. And Goldman Saks did that and they couldn't find a good name for it, so they had a contest and they called it Johns Hopkins. [Laughter]

ED HOWARD: Let me take a card question. Dr. Reinhardt mentioned the importance of making hospital pricing more understandable and accessible to consumers, do Mr. Kahn or Ms. Steinberg anticipate a time in which hospitals will begin posting prices in the name of transparency? Let me just add to that sort of a followup question. I would be interested in your opinions of the Maryland Hospital pricing system in which all payers pay the same thing. It makes it a little easier for those of us on the outside to understand.

MALE SPEAKER: I'd rather not. I think that over time, if the policy makers wanted, we can figure out what the best metrics are to make public. But I go back to the point that Uwe made, at the end of the day, it's really beside the point, maybe we should do it, but it's beside the point, the issue in our current system, unless you're going to change the insurance system is, if you have an Aetna policy, what is the cost sharing for you, as an Aetna enrollee, if you wanted

to go to each of the hospitals in Washington area, and Aetna ought to be telling you that. And United ought to be telling you that. Blue Cross ought to be telling you that. Because they have bought the services for you wholesale. They have made the negotiations and then you pay the copayment. It's the copayment that's important to you, not the raw price. Now, there are people that are uninsured and hopefully we are seeing movement there in terms of finding a managed care-like price for them, albeit it it's never going to be as low as the contractually arranged prices. And it shouldn't be because wholesale business is based on volume, and the individual person walking through the door doesn't represent volume. But it's the insurance company's responsibility if they play any role, if they have any value added, to tell people if they want to be covered by that insurance company, how much it's going to cost them if they go to the big providers in the given area.

ED HOWARD: Anybody else? Let me just ask how you respond to Uwe's touching on the consumer-driven plans in which there is a very substantial exposure, in some of these policies well under the amount that you might get from a short hospital stay anyway, so are they negotiating those same prices for you in Aetna if they're selling you a $10,000 deductible policy or should they? And how is that going to play out from the hospital's standpoint?

CAROLINE STEINBERG: We did do a survey about a year ago to try to understand the network and discounting policies and all the policies associated with the consumer-directed

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plans, and what we found in our survey was that 95-percent of the enrollment was in plans that were built on existing networks and discounting practices. So these were the Aetnas, the Blue Crosses, and the Signas that were building the consumer-directed products on top of the discounts and networks they already had.

ED HOWARD: Fair enough. The next question is for Uwe. Is the problem of inappropriate charges or costs in the charge master more or less severe for outpatient procedures and services?

UWE REINHARDT: I really wouldn't know how to answer that. It's just part of the charge master, the outpatient service, and I would imagine the same ratio of sticker prices to actual prices that are negotiated and obtained. Chip, you might know that.

CHIP KAHN: Most people have either a contractual relationship or a regulated price, and so it's really the same outpatient where the charges play into those formulas, and there's a cat and mouse game to keep the charges going up so you can get the best bang out of the formulas. It's the same there. There's not that much more retail there, because that's in a sense what the question is, is there more retail activity there that makes those prices more market oriented? And the answer is no, and I would argue that you don't even see that per se in the physicians' offices. Physician's prices or charges tend to be very high, and if any of you have gone to the physician lately, when you get the allowed amount

that the insurance company said they would pay, it usually is extremely lower than the amount that the physician had in their charge master. I'm not criticizing it; I'm just saying those are facts.

ED HOWARD: Two quick factorial questions. One, are there physician-owned specialty hospitals in the Washington area? And second, can states make meaningful payment reforms, or does it require federal reform?

CAROLINE STEINBERG: There are not to my knowledge any physician-owned specialty hospitals in this area. What was the second one?

ED HOWARD: To sort of add to that answer, generally in states with Certificate of Need, which Virginia, the District, and Maryland presumably all are, you don't find these hospitals. So you don't find that many of them east of the Mississippi because at least right now, Indiana and maybe one other state that I'm not thinking of east of the Mississippi don't have Certificate of Need. Although I think Florida and Pennsylvania may ben in some stage of repealing their Certificate of Need. Somebody from Pennsylvania may know more about it.

ED HOWARD: And if you can see that there is a need for payment reform, can states do it?

MALE SPEAKER: I guess my argument would be, just as in everything else in healthcare we've been there, done that and

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there's sort of one dinosaur, which is Maryland. And I think it is sort of anachronistic and things have to be done more broadly.

ED HOWARD: See you did answer my question; you just took a couple of questions later to get to it, that's all. [Laughter] In the DRA, congress cut 2.8 billion dollars [inaudible] rights from imaging services by paying the lower of the CPT code versus the APC rates, and some of you actually must know what that means. [Laughter] Physicians who perform images are very concerned about this. Are hospitals? Will hospitals be revamping their costs for imaging services?

MALE SPEAKER: It basically brought them down to us.

MALE SPEAKER: I think you should be asking the ambulatory surgery centers.

MALE SPEAKER: I wouldn't have framed the question that way. [Laughter] I think what I was going to say is I think some of the reasoning that went into this is that when you look at things like imaging services, ASCs, ambulatory surgery, you find if you look at hospitals, ASCs, physician's offices, that type of thing that the most complicated patients end up in the hospital, or tend to go to the hospital more than they go to the other settings. If you take your reasoning further and also argue that hospitals have greater regulatory burdens than some of the other settings, I think that is what some of the thinking was. Now whether it means that the hospitals are

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going to be rethinking things, I wouldn't see that off the cuff.

ED HOWARD: I've got a question here, I'm not going to read exactly what's on here because I don't think it's appropriate. [Laughter] [Interposing] It's about the American Hospital Association and apparently our selection of some materials from AHA and it is charged in this card that this particular piece of paper is filled with inaccurate and misleading information. I would invite whoever did this either to go to a microphone or describe what it is you're talking about; I'd be delighted to hear that. Or if you don't want to do that, and I can understand why, let us know what you're talking about. And if you have some corrections that you'd like to see, we will make sure that people who know a whole lot more than I do who agree with you have that posted on our web site as well. So, I don't want to skate past this. This is somebody on a congressional staff they say and that's our audience. We want to make sure we're fair to everybody on the panel and in the audience. We don't seem to have any other question either by card or by oral. I'm going to give the panelists, if they chose to, the chance to make 30 seconds worth of concluding remarks, which will give you just enough time to fill out those evaluation forms. Mark?

MARK MILLER: I don't think I have any concluding remarks about my talk. The only thing I would say is about the

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pay-for-performance stuff that Chip walked through. I think it's critically important that you understand that the impacts that he's showing there, and there's no criticism implied here, are very dependent upon the assumption made. And in our set of principles that we put out, for example things like rewarding improvement as opposed to just attainment, how much of a reward that you give to the hospitals could result in a very different set of distributions there. And Chip acknowledges that in the piece, and so this is not a criticism, but I just do not want to average person walking out of the room and saying, that's MedPAC's plan. They're definitely taking our framework and making a set of assumptions, and I think it's entirely reasonable to go back and do it, but there are a lot of things that could be played differently inside that simulation and produce very different results.

CHIP KAHN: Let me sort of take that on and leave you with this thought about pay-for-performance. Paying for performance, or the payment side of it, however you slice it, whatever assumptions you use, is not directly related to the specifics of these measures and, at least in terms of the future I can see, won't be. I'm not saying we shouldn't have pay-for-performance, but I'm saying we have to be very careful with the magnitude of money that we put into the pots that we use with whatever methodology, because there's a limited connection between that money and the measures even though they

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will send a strong signal to hospitals, or other providers if you expand it, to change what they do. Getting them to change is good, but if you put too much money in here, you're going to end up with distortions in payment that don't make sense. Just to give you one example before I drop off, with all due respect to someone in the room, if you look at the finance bill as past the committee, you would see some payments going up 39-percent for some particular procedures and things, which really doesn't make sense. They're not in scale with the kind of changes you want to bring about or the kinds of behavior you're going to affect. So I think you've just got to make either the reward fit the good behavior or the penalty fit the crime, and that's really important for this if you're going to try to apply these kinds of changes to payment.

ED HOWARD: Caroline? Uwe?

UWE REINHARDT: Yes, with respect to pay-for-performance, I happened to have written a paper on that for an audience in Taiwan, it was more like a teaching paper. I was overwhelmed in the end by how complicated it is to do that right. And my conclusion was we should certainly try it, on the other hand, I wouldn't assume that could solve all our problems. Chip's remark that just making the data available to professionally oriented type A people will probably do a lot more than fiddling with the payment system. To get some humility in that score, for some 15 years now we have tried to

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develop pay-for-performance systems for corporate executives. And as you know, 10 big mutual funds just submitted a letter to the SCC saying there seems to be no correlation between what executives get paid and their performance. Sitting on boards of companies, I tell you that it's extremely difficult to actually develop these systems. You'd be surprised how hard it is. You could say the one measure is stock price, but stock prices are driven by many factors outside of the control of the CEO. So then you have earnings per share. But then, if it doesn't affect stock price, why reward something that doesn't do anything? Overall, in the end I think people are just throwing up their hands. If we actually make that slightly work in healthcare, we would have and could take pride in, having trounced the entire corporate executives of America. Just think of the challenge ahead of us and how proud we could be if we did anything at all in this regard.

ED HOWARD: So watch this space, we will have that program later in the year. [Laughter] I want to, once again, thank John Iglehart and *Health Affairs* for their cosponsorship and active shaping of this program. I want to thank the Alliance staff in Montgomery who did a lot of work on this program. I also wanted to take note of the newest member of the Alliance family, Lisa Swersky's [misspelled] new son Noah who is now 10 days old. And I ask you, before fill out your

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evaluation forms, to join me in thanking our panel for a very helpful discussion. [Applause]

[END RECORDING]

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