ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 18, 2019
1:32 p.m.

MEMBERS PRESENT

Senator David Wilson, Chair
Senator John Coghill, Vice Chair
Senator Gary Stevens
Senator Cathy Giessel
Senator Tom Begich

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION: HEALTH CARE COSTS

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

DAVID HYMAN, M.D., Co-author
Overcharged: Why Americans Pay Too Much for Health Care
Law Professor
Georgetown University
POSITION STATEMENT: Presented on the cause of high health care costs.

CHARLES SILVER, Co-author
Overcharged: Why Americans Pay Too Much for Health Care
Law Professor
University of Texas
Austin, Texas
Adjunct Fellow Cato Institute
POSITION STATEMENT: Presented on the cause of high health care costs.

ACTION NARRATIVE

1:32:00 PM
CHAIR DAVID WILSON called the Senate Health and Social Services Standing Committee meeting to order at 1:32 p.m. Present at the call to order were Senators Giessel, Stevens, Begich, and Chair Wilson.

Presentation: Health Care Costs

1:32:12 PM
CHAIR WILSON announced the presentation Health Care Costs by Charles Silver and Dr. David Hyman. He noted that many people thought that Alaska was so different, but the presentation might show why health care in Alaska is not so different in many aspects.

1:33:12 PM
DAVID HYMAN, M.D., Co-author, Overcharged: Why Americans Pay Too Much for Health Care, Law Professor, Georgetown University, said the views are his own. He is not representing Georgetown University. The Pacific Coalition Health defrayed some of the travel expenses and the book was published by the Cato Institute in 2018. It is a reasonably comprehensive treatment of why health care in America is so expensive and explains the ever-increasing costs.

Dr. Hyman said the book is hundreds of pages. He is not presenting himself as an expert on Alaska. Every state is unique and faces different challenges because of the specifics of their health care market and the broader economics within each state. He was hired as an expert on behalf of the State of Alaska in its Medicaid suit against the pharmaceutical companies that resulted in a recovery for the state of about $45 million a few years ago.

DR. HYMAN shared slides of news articles about shockingly high bills: "Family outraged, billed $800 by hospital to use sink." "$12,000 for bee sting? Emergency room visits get even pricier." "A baby was treated with a nap and a bottle of formula. The bill was $18,000." "Life-threatening heart attack leaves teacher with $108,951 bill."

DR. HYMAN showed a story with the headline, "To fight high drug prices, Utah will pay for public employees to go fill prescriptions in Mexico." Utah is a conservative state but facing high pharmaceutical costs for state employees for specialty drugs. Even very conservative states have gotten creative to deal with spiraling increases in costs.

DR. HYMAN shared another story from last week with the headline, "Walmart is so desperate to fix health care, it flies employees to top hospitals in other states for treatment."

DR. HYMAN said these show the degree to which the health care system is not doing a great job for patients or people paying for health care.

1:41:03 PM
DR. HYMAN showed Martin Shkreli, the face of Pharma Greed. He raised the price of Daraprim from $14.50 per pill to $750. A representative comment from potential jurors was, "I could be impartial to which prison he goes to."

DR. HYMAN said the reality is that even if Shkreli had doubled the price increase, it would just be a rounding error in the total pharmaceutical spending in this country. The most important point is that Shkreli followed a path that had been well established with generic drugs. Generic drugs historically had been a success story in terms of affordability, but lately there have been a variety of examples of dramatic price increases in generics, some of a thousand percent. They see the same thing in branded drugs as well with dramatic increases, with insulin, for example. Harvoni is a miracle treatment for hepatitis C. It is a cure, but a very expensive cure. Many state agencies are struggling with whether to cover it. Prisons face this issue.

DR. HYMAN said drugs for the treatment of cancer are coming into the market with very high cost points with marginal evidence of effectiveness. The Office of the Inspector General in the U.S. Department of Health and Human Services stated in 2018, "Total reimbursement for all brand-name drugs in Part D increased 77 percent from 2011 to 2015, despite a 17-percent decrease in the number of prescriptions for these drugs."

DR. HYMAN said health care spending can be thought of being composed of a volume effect times a price effect and total spending equals volume times price. One issue is about volume--are they overproviding certain kinds of treatment relative to

what the best medical evidence suggests (sometimes underproviding a treatment is also an issue), but a lot of issues faced in multiple states is about the price effect, the price per unit more than volume.

DR. HYMAN said branded drugs have high fixed costs to develop and test for efficacy and safety and then low production costs. Biologics have a much higher manufacturing costs, so the disparity of pricing between branded and generic biologics is not as big.

DR. HYMAN said that Shkreli became so notorious that the Lown Institute in Massachusetts named its annual award for egregious price the Shkreli Award. Pharmaceutical companies set their prices high because they can and society has chosen to pay for what they ask, particularly for Medicare Part B.

DR. HYMAN said the book has a litany of all challenges and problems with the health care system: "Open-ended reimbursement for patented pharmaceuticals, regardless of price. Excessive use of medical treatments. Providers' conflicts of interest. The routine delivery of ineffective and unproven treatments. Games that providers play to maximize their revenues. Charges that bear no relation to costs. Surprise bills and other out-of-network rip-offs. Widespread quality problems tied to dysfunctional business models. Political corruption. And an ocean of fraud." The basic difficulty is that everywhere one looks in the health care system one finds problems relative to what people want out of the health care system, which is high quality care, doing the right thing right, and delivered at a price that people can afford.

1:47:53 PM

CHARLES SILVER, Co-author, Overcharged: Why Americans Pay Too Much for Health Care, Law Professor, University of Texas, Austin, Texas, Adjunct Fellow Cato Institute, said dysfunctions are everywhere in health care. Most of those dysfunctions cost money, meaning the services are more expensive than they should be, or the money is not spent on services at all, or the quality is variable. The situation in the health care sector differs from the private sector. In general, there are too many things to police. America has an administered system administered by government agencies, Medicare/Medicaid, TRICARE, and private insurers. There are enormous agency costs when third parties are used to administer a system, rather than the consumers who are purchasing and benefitting from the services. Those agency costs appear in every single relationship. Every relationship between

a provider and a patient has agency costs. Every relationship between an insurer and a provider. Between the government and provider. Between the government and a supplier of medical devices. These are all interactions where there needs to be incentives for the service provider to do a good job at reasonable cost. Those incentives are created automatically in market transactions where consumers look for value and good quality at a reasonable price and have options. In an administered system, those incentives are not created automatically. Consequentially, there has to be monitoring and oversight, but there are too many interactions to oversee. There are billions if not trillions of interactions every year in the health care system. There are more than a billion visits to doctors' offices ever year.

DR. HYMAN reviewed different dysfunctions on slide 12. They range from some simple overutilizations of services to outright fraud. Medicaid and Medicare are large pots of money that are not policed effectively. Fraud involves mainstream providers, high-end academic medical centers, and Fortune 500 companies. The standard estimate is that about 10 percent of health care spending is lost to fraud and abuse; if waste is added, the numbers start to get up to the low 30s.

1:52:50 PM
SENATOR COGHILL arrived.

DR. HYMAN said he is often asked why organized crime is on the list of those who commit fraud. He quoted Louis Freeh, who was the FBI director in 1995: "Cocaine distributors in Southern California and southern Florida are diversifying into Medicare abuse because the profits are greater, the chance of detection is slimmer and the penalties are minor."

DR. HYMAN said examples of apparently-reputable mainstream providers show how agency problems and the lack of policing can result in patients being harmed and large amounts of money being stolen from programs paid for with tax dollars. He gave the example of Dr. Jacque Roy who was a primary care doctor in Texas. Dr. Roy took the federal government and home health care agencies for $375 million for services that were not provided to anyone. Because the paperwork was in order, the Medicare program assumed services were being provided. It was a was a simple scheme. Dr. Roy signed a piece of paper certifying that a patient needed home health care. A physician usually certifies four or five people per month. Dr. Roy wrote 5,000 in a year. If

anyone was paying attention, he would have stuck out like a sore thumb, but no one was paying attention.

1:55:42 PM
SENATOR STEVENS called the Dr. Roy story shocking. He asked if ethics are taught in medical schools.

DR. HYMAN said ethics were taught to him in medical school and he is confident they were taught to Dr. Roy as well. However, being taught ethics is not a sufficient constraint when large pots of money are available if someone breaks the rules. The rules are only meaningful if they are enforced.

SENATOR STEVENS said that is shocking.

1:56:41 PM
SENATOR GIESSEL commented on the importance of utilization review. A dentist told her that the state has a sudden epidemic of lip tie and tongue tie procedures by dentists. Babies have to be able to move their lips and tongues to speak appropriately. Occasionally a sheet of tissue extends too far on the tongue and the physician must clip it. The same is true for the upper and lower lip. Suddenly the state has an epidemic of this and dentists are performing them right and left. This particular dentist had seen these children before they went to other dentists who says they are pediatric dentists but aren't. Suddenly children are having these procedures which she was told bill to Medicaid $1,100 and Medicaid reimburses $500 for the procedure, but the procedure was not needed. That was one example from one clinician in the state. If Medicaid did utilization reviews, these procedures would be flagged and these would stop to save money and prevent unneeded procedures on children.

1:58:29 PM
MR. SILVER responded that Alaska is not alone in having an epidemic of unnecessary tissue snipping. They have read of this in other states as well. The problem with monitoring this kind of behavior is that they cannot rely on paperwork to determine if the procedure is needed. The paperwork will say whatever it needs to say in order to qualify for treatment. An actual review of the patient and underlying medical information is needed. That is incredibly expensive and imagine doing it on procedures performed hundreds of thousands of times. When people buy services themselves, they will not pay for tissue snips they don't need. They need built-in incentive not to get unnecessary

treatments. Whenever that incentive is taken out, monitoring has to be substituted, which is costly.

DR. HYMAN said the book has a discussion of exactly this type of problem, which they call billing-related epidemics. California had an epidemic of kwashiorkor, a protein deficiency disease seen in sub-Saharan Africa during famines because one prominent provider in California discovered that it could juice its billings by coding Medicare patients as if they had protein deficiency.

MR. SILVER said they should be careful talking about ethics and the lessons not sinking in. It doesn't take a high percentage of unethical providers to milk the system for billions of dollars. There are about a million-and-a-half physicians in the United States. If three or four percent of physicians are willing to do these things, that would be 40,000 to 50,000 doctors out there doing bad things. No one can police that many people. He is a lawyer and could say the same of his own profession, but attorneys don't have access to the public treasury. It is the death of a thousand cuts. Every time physicians have an opportunity to treat a patient or submit a bill, they face a temptation created by the payment system to do something slightly wrong, to overtreat, to recommend a scan a patient doesn't need, to code a procedure one level higher than delivered because every one of these little steps increases the payment the provider receives. Over time they come to see these things as normal. He doesn't want to say people have bad characters. There are some, but for many people it is just the way they are accustomed to doing things and getting rewarded for it, so nothing changes.

DR. HYMAN said that although the book focuses on bad apples and problems, this is not to suggest that all health care providers should be presumed guilty. There are lots of wonderful doctors. Most do their best for their patients, but they don't create problems the regulators need to deal with. For obvious reasons, he and Mr. Silver will focus on the bad apple problems.

DR. HYMAN said an example of a bad incentive is treating wet macular degeneration. Off-label use of Avastin is a success story for treating wet macular degeneration. Avastin has a low price for treatment of wet macular degeneration of $60 a dose. The company created the exact same drug, Lucentis, that carried a price of $2,300 per dose.

MR. SILVER said the difference between Avastin and Lucentis is how the dose is labeled.

DR. HYMAN said it is the same medication but depending on which drug is used to treat wet macular degeneration, the patient faces a very different cost. The patient pays 20 percent of the drug cost. Because of the way Medicare structures reimbursement for physician dispensed drugs, the doctor gets 6 percent of the cost of the drug. (It is now 4.3 percent of the cost of the drug.) If the physician uses Lucentis, physician gets much more money. If patients paid out of pocket, physicians could never use the more expensive drug if they knew the lower-priced drug was available. The good news is that many ophthalmologists used Avastin, but some did not, enriching themselves.

2:08:21 PM
SENATOR STEVENS asked if all doctors receive a kickback.

DR. HYMAN said the Medicare program must figure out a way to pay physicians for the services provided to Medicare beneficiaries. For Medicare Part B, they pay physicians a fixed percentage of the cost of the drug dispensed. That is the way the Medicare program compensates physicians. It is not a kickback payment for providing services. It is designed in a peculiar way. It is not about the value of the service being provided. It is not a sensible way of structuring payment for service. This is how Medicare pays for physician-administered drugs with Part B, not for drugs obtained with a prescription at a drug store.

DR. HYMAN gave the example of another bad apple, Dr. Salomon Melgen. He was an enthusiastic user of Lucentis. Almost every patient of his was diagnosed with wet macular degeneration. He quadruple billed Medicare for Lucentis and was paid $135 million by Medicare. Medicare wanted some of the money back. Dr. Melgen made large campaign contributions. Senator Menendez of New Jersey went to bat for him with the Centers for Medicare and Medicaid Services. A senior staff member for Dr. Melgen said, "Bad medicine is not illegal. Medicare should pay these claims." Politics will intervene to continue the flow of funds to someone not providing the quality of medicine people would like.

MR. SILVER said health care was one of the main issues in the 2016 election. People are very worried about many different things when it comes to health care, but according to at least one survey, surprise medical bills is the thing people worry about the most. People receive surprise medical bills from providers who are out of network. These are balance bills, bills

to the patient for what remains after insurance pays. Many come from emergency rooms. Hospitals contract out the management of emergency rooms to independent companies that do not belong to the same network that they do. Every patient who thinks the hospital is in network is at risk of receiving one of these surprise bills. Another common service that is not part of the network within hospitals is for anesthesiologists who are typically independent contractors, not doctors on the hospital staff.

MR. SILVER said the question is why people see balance billing so often from health care providers. He uses the metaphor of an auto body shop. The hospital repairs bodies. He said to imagine if someone took a car to an auto body shop and six months later got a surprise bill from someone who had painted the bumper on the car because that person was an independent contractor. Most people would react with outrage. The shop is supposed to bundle the services and charge one price. He asked how hospitals can get away with a practice that does not exist anywhere else in the service sector. The answer is a lack of competition.

MR. SILVER said an auto body shop who did this would not remain in business. In the medical sector, hospitals don't face this problem. They don't lose business when sending out surprise bills. They did see one study recently that showed hospitals are starting to lose business because of this practice. Until now, hospitals have been able to let independent contractors send out these surprise medical bills without fear of losing any revenues. If hospitals had more competition, patients could go to places that protect them against this financial risk. Some hospitals refuse to allow contractors who are not in network to balance bill their patients. They would love to see hospitals who do this advertise this.

MR. SILVER said if they can get prices to matter to patients, patients can shop for health care and the problem will take care of itself.

DR. HYMAN said the study Mr. Silver referred to was published last week in Health Affairs. The study focused on mothers who had given birth at a hospital and whether they returned to the hospital for subsequent births. That is different from typical emergency use. People don't want to go to emergency rooms, and they don't have much choice about what emergency room to go to. It is not the same circumstance as a mother choosing a hospital to give birth a second time. He noted that he has a white paper

coming out this week about surprise medical bills that expands on some of the ideas in the book.

DR. HYMAN said they would ask the broader question of why the health care system is so dysfunctional.

MR. SILVER said the dysfunction stems from the payment system. A large chunk of what is wrong is traceable to the dominance of third-party payment arrangements. The health care system differs from everything else. People don't use insurance to buy a car or fill it up with gas. America is using insurance the wrong way. Americans don't use insurance to pay for many things. Americans reserve insurance for catastrophes. That is the way insurance works best. Insurance works best when it deals with low-probability events with catastrophic effects. When those accidents do happen, insurance imposes a substantial out-of-pocket payment on the insured in the form of a deductible, so someone always has skin in the game to do whatever is appropriate to reduce the likelihood of a catastrophe happening.

2:23:55 PM
MR. SILVER said insurance is used very differently with health care. Insurance pays for relatively small, predictable costs, such as a routine doctor visit. They have a network of comprehensive insurance rather than catastrophic health insurance where predictable costs are paid for. In effect, insurance companies are used as prepayment schemes. People pay them a bunch of money and then the companies pay a bunch of money out for things people will predictably and regularly need. The problem is that insurance companies are not good shoppers. They are simply there to pay the bills.

MR. SILVER described the associated tax subsidies. For employer-provided insurance, the premiums are paid with pretax income, which makes it extremely desirable to buy in that way. It is making insurance cheaper. When there is a tax exemption for something, people want to maximize the value of the tax exemption. With health insurance they do it by making insurance more comprehensive. The more that can be under the umbrella of insurance, the more the tax exemption can be used for insurance premiums for someone's advantage. People want insurance to cover as many things as possible, so there is a network of comprehensive insurance. Comprehensive insurance is expensive. Most people are paying $20,000 a year or more for family coverage through an employer. They want to consume services worth at least some of that. When that insurance coverage is used to buy things, people don't have to pay much at the point

of delivery. The average recipient pays eleven cents on the dollar for medical services, so there is a low threshold to using the services as well. The whole arrangement is structured to maximize the amount of insurance benefit and thereby, the amount of health care consumption. It keeps growing upon itself. People who benefit from the network who want the exemptions continue to funnel money into the political system. Then there are insurance mandates and limitations on market entry. All of these things either cause demand to go up or supply to be constrained. The net effect is that prices go through the roof.

MR. SILVER said that for diverse reasons, prices in the American system are far higher than in any other country. It is possible to untangle them to see how the system keeps driving demand up and up and therefore escalating prices. This is not a not a new thing. He and David did not discover this. As seen in the book, the work on "this vicious cycle" is traceable back to the 1970s. With the creation of Medicare and Medicaid, hospitals and doctors immediately started raising prices by significant amounts. Previously the price of health care had risen at the rate of inflation, just like everything else. Then it started tripling and quadrupling compared to the rate of inflation. It was simply that demand was increasing with essentially an unlimited supply of money to pay for services and no one was forcing prices down. As private insurance spread, the situation became worst. The country is reaching the crisis part of the cycle. The famous economist Herb Stein said that if something can't continue forever, it will stop.

2:30:03 PM
MR. SILVER said he thought they were at that point. They are seeing large increases in insurance prices and in taxes that have to pay for this. States are reaching the point where they can't afford the medical services they are providing through Medicaid. People are being forced to opt out of the system because they can't afford to buy the coverage they need. The country must figure out what comes next because other people's money to spend on health care will run out.

DR. HYMAN said on what comes next, a chapter in the book is called "Blind Alleys and Lost Causes." They discuss a variety of strategies they think are unlikely to work out as their proponents hope. One of the most prominent politically at the moment is single payer. They do not think it offers an effective long-term solution. The first question is which single payer. There are a variety of federal and state programs that are very different. Medicare for all is very different from Medicaid for

all which is quite different from Veterans Affairs for all. It is useful any time people speak about single payer to ask which one do they mean and how well do they understand the tradeoffs in the choices.

DR. HYMAN said another point is that regardless of which one people choose, they have high on-budget costs for doing it. The best-case scenario for scoring a single payer scenario like [Vermont] Senator Sanders' proposal is that it will result in an additional $33 trillion in new spending over the next ten years in addition to the amounts already being spent on health care. This is doubling the cost. The money must come from somewhere. In fairness, it will be viewed as a replacement for the current amount people are spending, but this is a sizeable increase, roughly doubling the tax rate to where the country is now. Advocates are willing to envision a policy based on that, but three states have flirted with a single payer proposal, Vermont, California, and Massachusetts. These are deep blue states with favorable politics, but all three states gagged at the cost of single payer. Although advocates are willing to increase taxation and government spending, it is not obvious that voters are.

2:33:48 PM
DR. HYMAN said the book goes into detail about the standard argument that single payer is more efficient than insurance. The typical basis is to divide the administrative costs for Medicare into the total Medicare budget and say and it is only one-and-a-half to two percent compared to ten to 15 percent for private insurance. A lot of money will be saved on administrative overhead. The book points out that this is not a good measure of program efficiency. One difficulty is that if Medicare overpaid twofold for every service, this measure would make Medicare look more efficient. Their measure is how much does Medicare spend to get a dollar in appropriate care to a beneficiary. If they take seriously the estimate that fraud and abuse is a third of Medicare spending, Medicare does not look good on efficiency grounds [52 percent to deliver $1 in care]. The expected reduction in administrative overhead to fund the proposal will not materialize.

DR. HYMAN said the retort is if all other countries can do it, why not the United States. There are a number of reasons, but one reason is the representative democracy that is uniquely responsive to voter interests and voter concerns who say why can't they be covered for x. Other countries are harder nosed about rationing. He showed a quote from the book:

"Relative to governments in other developed countries, the U.S. government appears to be unusually subject to pressure from special interests and uniquely incapable of rationing. It also often behaves as though it is run by idiots." (Silver & Hyman, 2018)

MR. SILVER said some of the difficulties in fixing the system is because of the divided levels of government. Medicare is a federal program and changes to that would be at the federal level, not state. Some of these changes are politically unlikely to occur because of interest group pressure to maintain them, for example, the tax subsidies for employer-provided health insurance. They have to ask, realistically, what can be done within the existing political constraints to make the situation better. They have to take advantage of the system's weakness, which is it cannot cover everyone. Things are so expensive that people are opting out of the system. People can't afford to buy comprehensive health insurance, so they are going without. That was supposed to be fixed by the Affordable Care Act, which was going to force everyone into the exchanges. Now they know that is not happening.

MR. SILVER asked so what can be done to take advantage of the problem. The Affordable Care Act (ACA) over the exchanges leaves people with high deductibles. The typical deductible for a family of four is $12,000. They are spending a lot to get insurance, but before they take advantage of it, they have to go through $12,000 worth of health care. That means that they will be looking for value. They need to take advantage of people who are spending their own money on health care by turning them into a driving force for health care reform by making it as possible as they can for them to get good services at reasonable costs. They should be trying to facilitate the development of the retail health care sector. It is already surprisingly large. It is growing and it is innovative. Amazon, Berkshire Hathaway, and J.P. Morgan have bonded to create a new organization called Haven. It is supposed to explore innovative ways of delivering health care. It has not done much yet, but some watches have different health care features and minute clinics have reasonable hours and posted prices. A search online shows many services available at retail. Lasik is not covered by insurance. It is sold the same way ordinary products are sold. People can find the prices. Web sites will even tell the average cost by area. Over the past decade, the cost of Lasik has declined and it has gotten better. The market is delivering the service.

2:41:13 PM
MR. SILVER said some might remark that the market can't deliver complicated services, but it can. Groupon ads can be found online for cosmetic surgery, which has gotten cheaper and the volume has increased. It includes anesthesia, so it is complicated. The Surgery Center of Oklahoma is the future of health care. The Surgery Center does not operate with insurers. It operates on a cash pay basis, sometimes by the patient and sometimes by the employer. Its pricing is totally transparent and reasonable and has a straightforward relationship to its costs. The price for the joint in a hip replacement procedure is what the Surgery Center pays for it. The center does not make a profit on the mechanics. An ordinary hospital buys something for $100 and sells it for a $1,000. Goods are profits for hospitals, but not the Surgery Center. The cost is about one-third cheaper than other hospitals in the area that take insurance.

MR. SILVER said that as he sees it, this is the way of the future. There are many services out there delivered at retail. They have ideas about how to encourage the growth of the retail sector through the Medicaid program, for example. Medicaid could direct patients into the retail sector and give them more control. Those will develop a norm of purchasing at retail. Once the norm is developed that is very big. People will think it is normal to spend their money on health care the way they do everything else, and then the retail sector will really take off.

CHAIR WILSON said they brought up the Surgery Center of Oklahoma. Several different hospitals and other groups have visited his office this session and told him that if surgery centers are allowed, the hospital will go under because the surgery centers don't have to deal with EMTALA [Emergency Medical Treatment and Labor Act], with emergency rooms, and will take the profit center away from the hospital and close the hospital. He asked how that would work.

2:45:13 PM
DR. HYMAN said that to frame the objection in a more candid fashion, they are saying you must overpay us in this area for us to provide services in another area. The best response is that if they are purchasing health care services, they should buy the highest quality at the lowest price, regardless of who is delivering those services. If there are other services that people want provided that patients cannot pay for, the providers should be subsidized to deliver those services. Or better yet, give the money to the patients and let them decide where they

will receive those services. This is exactly the same argument used by the Bell system as to why they should overcharge for long distance calls in order to subsidize local calls. That argument as an antitrust matter was not successful, which is why everyone is walking around with a fancy cell phone in their pockets. If they want services to be provided for people who can't pay for them, then they should subsidize either the delivery of those services for the patients who need them, but they shouldn't allow people to overcharge a significant chunk of the customers or to perpetuate inefficient business arrangements merely to deliver some subsidized serviced elsewhere. The hospitals are subsidized to provide those services through a variety of other mechanisms. It doesn't follow that that they should be allowed to overcharge all comers.

2:47:04 PM
SENATOR COGHILL said that is the dilemma in his community. The profit centers subsidize the others. They say the Medicaid rate can't cover the costs and they can't turn anyone down by law. Those are the struggles they have. The ER can't turn anyone down, so that is the loss center. Putting the rest of the enterprise aside, the ER is a losing business that the government has put on them. It illuminates the dilemma in his town. In his town they have become more things to all people, which makes it even tougher to get out of.

DR. HYMAN responded that it is a challenge. People want everything but balk at the cost. The current arrangements are unsustainable. They need different strategies for addressing it. One strategy is to keep writing bigger checks. When people find themselves in a hole, they should stop digging rather than finding a bigger shovel. Their argument is that the way services are delivered should be changed, which will change the cost profile of the hospital. If it has to compete, it will have to reengineer in its own processes and decide what it ought to do. They should not assume that the way the hospital behaves is unaffected by the mix of patients it sees. If it loses money on every ER patient, it may change the size of the ER, the extent to which it is conveniently located, and whether it is perceived as friendly or hostile. In large metropolitan centers people are more likely to go to different hospitals because they've gone there in a lot. In many communities in Alaska, there is only one hospital. They need to decide what they want to subsidize and then write checks for doing that. The problem with the Emergency Medical Treatment and Labor Act (EMTALA) is that the federal government imposed a mandate, but it declined to fund it. That is reckless and disingenuous. He hasn't been able to get

Congress to revisit the issue. Some hospitals face huge costs because of EMTALA and other face little costs.

SENATOR COGHILL said they have to live under that mandate. In a small town like his, there is one hospital that wants to have surgery centers and other things. They are struggling along and growing. In Anchorage, their capacity at the front door is a problem because they can't turn anyone away. That creates a huge problem. That is going to be a continual thorn in their side as they try to figure out how to get the consumer closer to the payment. He said he agrees that they need to get there, but they are starting with a directive from the federal government. It makes it difficult. It is going to take some creativity.

2:51:46 PM
MR. SILVER said he hates to say it, but pain is coming, no matter what. The local hospital that Senator Coghill is describing is already having to compete with hospitals out of state. He was reading about medical tourism from Alaska. The situation is that they overpay the local hospital for surgical procedures because of the ER losses. That is not a sustainable solution in a market where people can go other places. Rather than go to the local hospital, someone who is paying for the surgery will go elsewhere. There is a limit on how much of the subsidizing can occur. As the vicious cycle excludes more and more people from coverage, this kind of activity will increase. There are people who want to profit on these overpayment arrangements. They are physicians who realize they can make money because Alaska is willing to pay too much. There are places in Florida where lap band surgery or other weight loss procedures are a third of the cost in other places. People are starting to figure out they can go to Florida and have a vacation and still save money. As people get smarter and there are more surgery centers, these hospitals will face pressure anyway. The question is whether they want to be in front of it and figure out how to handle the problem of EMTALA or be on the back end. Even the emergency room thing is worth thinking hard about. One of the problems with emergency rooms is that people use them for nonemergencies. He would like to see triaging at the local level. Hospitals will send people elsewhere for nonemergencies. As competition develops, hospitals will be pressured to direct people to the correct places. Focus on the problem to be solved, which is uncompensated true emergency care and figure out how to pay for that.

SENATOR GIESSEL said she is hearing that the U.S. Senate Health Committee is looking at actual profits at nonprofit hospitals.

Senator Coghill was talking about Anchorage and hospitals being unable to provide services for people who cannot pay, but in fact, Anchorage has a large nonprofit hospital that has the highest profit margin in its West Coast system and is increasing its footprint on its nontaxed property. She asked if it is correct that Congress is looking at that.

DR. HYMAN answered that Congress has an ongoing interest in whether nonprofit hospitals are earning their exemption as 5013c tax-exempt organizations. Local tax exemptions can be a large amount of money. There have been a series of studies about whether hospitals earn their tax exemption by providing charity care. There is a wide variation among nonprofits and how many earn their exemption. Some are out there doing God's work and some of them considerably less so. The average nonprofit provides a percentage point more of charity care that a for-profit hospital, but there is substantial overlap in the distributions of the two types of hospitals. The ACA had a provision to compel nonprofit hospitals to disclose what they were doing to provide community benefit. Data is starting to emerge on what hospitals think they are doing to justify their tax exemption. Individuals senators are interested in looking at this, particularly with the surprise medical billing dynamic.

2:58:38 PM
CHAIR WILSON remarked that some of the examples suggested the only way to change this was through public shaming of the process. The medical system is incentivizing people who use superbills. There is now medical tourism and providers won't see those patients. He related that his mother-in-law had heart surgery out of state and her doctor would not do follow up care. Local providers are starting to push back. He asked what tools are available to commandeer bad actors and to lessen fraud.

DR. HYMAN responded that there are many things to do. Public shaming is not the most important. In well-functioning markets bad actors are not nearly as common, and news media brings attention to those problems. They ought to create incentives for providers through the payment system to serve the interests of their patients. Part of that is increasing competition in health care market by making it easier to obtain care and making it easier for people to enter the market to provide services. Well-functioning markets protect consumers. Encouraging market entry and competition is the most important thing to do. The emphasis on self-pay is to get patients interested in the cost and value of the care they are receiving. When people are spending their

own money, they evaluate their decisions differently than when they perceive they are spending someone else's money.

CHAIR WILSON stated that there will be follow up legislation working its way through the body. He offered to share copies of the white papers with the committee.

3:03:26 PM
There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee meeting at 3:03 p.m.