Presentation/Discussion
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Bob Blake
President
Affordable Health Care Facilities, LLC ("AHCF")

Introduction

This write-up is my summary of the presentation/discussion that I gave on March 24, 2010 at the SHCC public hearing on behalf of AHCF. I have included responses to the questions posed by Dr. Patel. I paraphrased Dr. Pate's questions as I remembered them. This write-up may provide a bit more detail and explanation than my actual oral presentation/discussion.

Thank you for allowing me to present at this Public Hearing. My name is Bob Blake. I am President of Affordable Health Care Facilities, LLC ("AHCF"). As many of you know, I have been writing petitions to the SHCC for a number of years now. My interest is truly to lower health care costs for the citizens of North Carolina while improving the quality of and access to health care services. In 2008, AHCF filed a petition that led to the formation of the SHCC work group that in turn led to the three (3) pilot demonstration ASC projects being made a part of the 2010 SMFP. This year AHCF's petition is related to the structure of the SHCC and the desire for more transparency in the deliberations of the SHCC and its work group meetings.

When we proposed the 2008 ASC petition, we felt that we would be included more in analysis and discussion done by the work group that was formed. Candidly, we

were not. There were meetings, often times via conference call. I attended (listened to) some of these conference call meetings without even other attendees knowing that I was on the call. I truly believe that the SHCC should be more open and transparent in its operations and deliberations. I encourage the SHCC to consider these requests.

Specifically, I believe that the SHCC's members have significant conflicts of interests. If a member works for an organization that has a CON, there is pressure for this member to support CON regulation. The member's objectivity is compromised. Therefore, the petition by AHCF requests that the SHCC be re-structured to have only members from business and industry, or perhaps other members without conflicts of interest and any direct participation in the medical industry. Then we would have a strong advisory board composed of health care providers to advise the SHCC voting members. The experience, knowledge, and overall value of health care providers to the SHCC should not be diminished. I just think that any member who has a CON, or whose organization does, should not be allowed to make health care policy related to SMFP.

I am pleased to see that the SHCC has new membership. I am not sure why the membership was changed by Governor Perdue. I have not spoken to anyone to inquire as to why. Change is good though. I look forward to working with you.

Now that we have health care reform, universal health insurance coverage will eventually take hold. If we have universal health insurance coverage, then the issue of uncompensated care and "cost-shifting" is diminished. Hospitals and other health care providers will no longer have the excuse that uncompensated care requires them to have higher charges and "cost-shift" to commercial payers. On a personal level, I am very concerned about rising health insurance costs for my family and as a small employer. This year I had a very large increase double digit from BCBSNC in my health insurance premium. Perhaps my health insurance costs rose because I am turning 52. I do not know.

Dr. Bruch asked a question earlier in the regular SHCC meeting about disproportionate share payments. AHCF's petition this year has an exhibit attached that shows all disproportionate share payments by the federal government to North Carolina hospitals in fiscal year 2009. In fiscal year 2009, North Carolina hospitals received more than $710 million in disproportionate share payments. So uncompensated care is not really uncompensated care. There is compensation for such care.

I have a real concern about the cost of health facility services in North Carolina. I believe that there should be more transparency. Why should a patient pay a different amount with BCBSNC, CIGNA, United Healthcare, or Coventry/Wellpath for the same health facility service? Worse yet, uninsured patients must pay billed charges and then negotiate discounts on their own. This is a travesty and certainly not equitable. There is a reason that this is the case though. Disproportionate share payments to hospitals are based on charges foregone. So hospitals have an incentive to keep charges rising in order to maximize disproportionate share payments and their revenues. In addition, there are other reasons as I will discuss.

It is interesting to note that Attorney General Coakley of Massachusetts – yes the same person who lost to Scott Brown – issued a "Preliminary Report" on the source of rising health care costs in Massachusetts one week after her election loss. Massachusetts is a state that has near universal health insurance coverage, but it cannot control rising health care costs, which are now beginning to strangle the state budget. Attorney General Coakley subpoenaed hospitals, large medical practice, and insurance payers as to their charges, reimbursement, and other data. She found that the hospitals with the most negotiating leverage were paid the most. There was no relationship to uncompensated care. Hospitals in more poverty stricken or poorer payer mix areas and with a higher level of uncompensated care often had lower reimbursement from private payers, such as the Blue Cross Blue Shield plans, Hospitals with better payer mix, less

uncompensated care, and located in more affluent areas have negotiating leverage to gain higher reimbursement for the same services provided to patients. This makes little sense from a health policy perspective. Attorney General Coakley also found that price was a greater driver of rising health care costs than utilization.

Dr. Greene discussed Dr. John Wennberg of Dartmouth earlier in her presentation. There is superior health policy and economic research being done at Dartmouth. The Dartmouth Atlas of Health Care project funded by the Robert Wood Johnson Foundation is an example. One can go to their web site and look at every 3-digit zip code payment region for Medicare in the United States. The map shows annual Medicare spending per enrollee. In a petition last year, AHCF presented this Dartmouth research. We showed that North Carolina's rate of growth for annual Medicare spending per enrollee exceeds that of the United States on average. So one has to question if CON regulation has had any effect on controlling rising health care costs over the past number of years. I would suggest not really, especially given the Coakley report and the Dartmouth research.

My point is that hospitals costs and resulting reimbursement by health insurance payers in North Carolina are way too high. There needs to be more value-based competition. The myth that hospitals need to charge so much and "cost-shift" needs to be debunked. So in addition to changing the voting member structure of the SHCC, other recommendations of this year's AHCF petition are:

1. If we are going to keep CON regulation, which may be a good thing in some cases, then we need to regulate price – that is charges and reimbursement for health facilities. We should do so in the form of a public utility model as the States of West Virginia and Maryland do.

2. The SHCC or some agency should be given the authority to establish maximum prices, again in the form of a public utility model, for licensed health facilities.

3. If nothing else, in communities where there are confirmed high charges and reimbursement, we should foster a relaxation of CON regulation and promote value-based competition among facilities. Otherwise, pure price regulation should be instituted.

If we are going to keep CON regulation, we at least need to regulate price. You cannot have monopoly and oligopoly market position held by hospitals without such regulation and control rising health care costs. This is basic economic theory regarding public utility like industries.

Health insurance payers cannot effectively negotiate with hospitals given their strong market position under CON regulation. I worked with CIGNA and negotiated hospital contracts. Here is what happens. Imagine going into a hospital CFO or VP of Managed Care Contracting and wanting to negotiate a contract as a health insurance payer. We start with inpatient. The hospital says not to DRG's and okay to per diems, but only with a charge-based outlier for the per diems. So if charges get over a total charge trigger threshold, then the entire reimbursement reverts to a discount off of charge contract. So inpatient care often reverts to a pure discount off of charge reimbursement.

Then what about outpatient services? Hospitals have lab, radiology, oncology services, surgery, DME, home health, pharmacy, and many other outpatient services. There is no one reimbursement approach or underlying formula for negotiation of each service line. One would have to be an expert in everything to negotiate multiple types of reimbursement. So what do the CFO's most often say? They only will accept a discount off of charges for outpatient services. I do not know of a hospital in North Carolina that has many, if any, outpatient services priced on a fixed price contract basis like they do with Medicare. There may be a few services, but the vast majority of hospitals in North Carolina are reimbursed on a discount off of charge basis for all outpatient services. So

there is a clear incentive for hospitals to keep raising charges as reimbursement will in turn rise. For the uninsured, this is very unfortunate as I said earlier.

On the other hand, health professionals, such as physicians, psychologists, home health care givers, and all others, are all subject to fixed price reimbursement by CPT code. The same rules should apply to hospitals. There are well qualified individuals who can develop fixed price reimbursement for every service line in a hospital. Such a reimbursement schedule would be "UCR."

Back in the 1980's before we had full blown managed care, PPO's, and HMO's, we had UCR reimbursement. UCR means usual, customary, and reasonable. There is nothing usual, customary, and reasonable about health facility pricing in North Carolina today. Unlike with health professionals, hospitals can keep increasing charges and reimbursement and "cost-shift" to commercial payers, the state health plan, self-funded employers, and others. Since we will soon have no more uncompensated care with universal health insurance coverage, I would argue that we need price regulation of health facilities given this situation, unless we can get more value-based competition and relax CON in certain high charge communities that can be identified. I am not sure that any increased competition should really occur in rural areas, because our state's rural health care system remains fragile.

Attorney General Cuomo in New York sued health insurance payers for understating UCR allowable reimbursement in relation to out-of-network coverage. Basically, patients had to pay more out-of-pocket due to the use of a below UCR reimbursement schedule for out-of-network care. The health insurance payers saved dollars under this scenario with an abnormally low UCR reimbursement schedule used for out-of-network coverage. The law suit settlement amounts totaled somewhere near $100 million. Attorney General Cuomo then formed in 2009 a non-profit company with the settlement amounts. This company is called Fair Health and is based at Syracuse

University. Fair Health is now building UCR reimbursement schedules that can be used nationally. Perhaps we in North Carolina need to some of the same.

Here is another point about uncompensated care and how the SMFP is constructed. I have reviewed many annual licensure renewal applications for facilities in North Carolina. Many of these applications do not have accurate data, especially related to uncompensated care, self-pay, etc. Inaccuracies in operating room counts even occur in some cases. Procedure volumes are often not accurate either. Last year, AHCF submitted a petition to have an accountant review the licensure renewal applications. This petition was rejected. Perhaps we should have re-submitted this petition again this year. How can CON regulation and the SMFP be based on inaccurate data? Otherwise the entire regulation and process are flawed.

Basically, we need more transparency in health care facility pricing at the very least. I believe that it is the responsibility and the duty of the SHCC to make such recommendations to the Governor and other policy-makers. People and patients need to know what health care services cost, so they can shop for value. I believe that if CON regulation cannot be relaxed to create more value-based competition for health care facilities in identified non-rural areas, as proposed in this petition and prior ones in years past, then we need full price regulation of hospitals and other health care facilities in North Carolina, just like in West Virginia and Maryland. Attorney General Coakley's "Preliminary Report" and The Dartmouth Atlas for Health Care support such price regulation. Basic economic theory related to public utilities supports the same conclusion.

Now that we should have universal health care, uncompensated care will be much less of an issue in future years. We need to act pro-actively to control rising health care costs. I would argue that health facilities should lower their charges to health insurance payers, self-funded employers, and other health plans that receive the cost-

shift" with the elimination of uncompensated care, instead of keeping this built-in earnings Disproportionate share payments to hospitals should cease as well. I would further argue that CON regulation has failed to contain the cost of private health insurance, or for that matter that of the North Carolina State Health Plan for our teachers and other state employees. The seriousness of controlling health care costs cannot be understated.

The SHCC serves an important purpose. Again, all conflicts of interest should be eliminated in its voting and membership as proposed in our petition. This is why AHCF proposes that SHCC voting members perhaps should be only from business and industry without any medical industry ties. Then the health care providers with knowledge, experience, and commitment can provide important input and recommendations to the SHCC for policy approval as an advisory board with specific tasks. Thank you.

Question #1 – Dr. Patel

Question #1 (paraphrased): I understand your point about regulation of ASC's. Sometimes people build ASC's just to eventually sell them to make money. Then the purchasing institution turns around and raises charges. How does your discussion address this issue of ASC costs, uncompensated care, and other similar issues?

Blake Response: Your question is a good one. When the work group reviewed our petition for ASC's last year, they ignored many key tenets that we included. Specifically, we said that any CON issued to an ASC should have price or charge maximums equal to 250% of Medicare. Second, the ASC's given CON's need to be located in non-rural areas. Third, we said that if an ASC did not treat a sufficient number of uncompensated care, Medicaid, and other patients – I think 6%, then they should pay a tax of sorts. If an ASC still did not comply, then the CON or license should be revoked.

Question #2 – Dr. Patel

Question #2 (paraphrased): Physicians often order pathology that seems to be questionably inappropriate. There seems to be an incentive to order pathology inappropriately. There seem to be unnecessary costs for the system in this area. How do you address this issue?

Blake Response: It is interesting that you ask this question. As many of you know, I have been an advisor to gastroenterologists or GI physicians for many years. GI endoscopy is the highest volume outpatient procedure in health care. And as a result, anatomic pathology for GI physicians is sometimes a revenue source, if they own their own anatomic pathology lab. Few physicians do so in North Carolina. I am sure that the GI physicians and pathologists will not be happy with this response, but if you are concerned about inappropriate testing, there is a pretty basic response Payers can pay a fixed sum per case for pathology. For me as a patient, I do not mind the extra testing, since pathology is a definitive diagnosis of cancer or no cancer.