

**Excerpted from Remarks to the Federation of American Hospitals' Convention 3/2/04
By Congressman Bill Thomas, Chairman of the House Ways and Means Committee**

.....the point that the secretary made in the letter to the American Hospital Association, which he said, based upon the office of Inspector General's examination, "This guidance shows that hospitals can provide discounts to uninsured and uninsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts. Indeed if you examine the history of government support in the area of health care and especially hospitals, there was legislation called (inaudible) Burton, which actually provided tax payer resources to build hospitals. And that one of the understandings was that there would be an outreach to those who were uninsured and couldn't pay their bills, can or couldn't pay their bills. In addition to that, some hospitals get preferential tax treatment if they structure themselves in the 501C category. Certainly the idea that your activities are tax preferred over other institutions that look exactly like you and perform exactly the same functions, would assume that the tax payer was getting something for their money by not having you subjected to taxes that other institutions that look just like you pay. And so not only, I think, is HHS going to investigate generally what's going on, not only the Commerce Committee, but I believe you're going to see the Weighs and Means Committee. Through the tax code, in terms of tax preferences, and certainly we wouldn't single out health our hospitals because frankly there's been a lot of activity over the last decade in the tax preferred area, the 501 C3, C4, C6, that requires a broader examination of just what is it the tax payer is getting for their money by allowing these various worthy activities to be tax preferred and that perhaps we might be more specific in outlining responsibilities or duties of these institutions if they prefer to remain under the tax preferred structure....

So there are a lot of areas that I think frankly need examination in this. And the last thing I'm going to do is attempt to address the uninsured directly with assistance and find out because they don't follow the old cookie cutter pattern they're being billed with meaningless bills that don't mean anything to the insiders. But apparently are being required to be paid by people who aren't part of the club. Just like the first-dollar, third-party coverage problem of how much things really cost, I think to a certain extent it's true in hospitals today that people don't have a good bottom line. And if you do, then I'd like to see that set of books and not the books that I've been shown. I'm not accusing anybody of having more than one set of books, but what most people do is kind of add up what things cost and then they throw a profit percentage on top of it so you know what your actual costs are and what your profit margin is. And actually that would be a refreshing way to do billing in hospitals because nobody pays any attention to what the quote, price is because it's all negotiated. It's like going to the automobile dealer and having a manufacture's suggested retail price sticker on a car, and nobody pays that. Now very few people get the brother-in-law rate, but in between the brother-in-law rate and the manufacturer's suggested retail price is what people actually pay. In the American Hospital Association Letter, just to me personally, was a little scary because basically their argument was, we don't know what to do. All of these rules and regulations and responsibilities require us to screw--excuse me--bill the uninsured at a rate that no one else pays and we must pursue them to be even handed in dealing with folk. That is, pardon me, very, very cynical. And, here we go again, not the smartest thing, rate (inaudible) because all that does is intensify my personal concern about the fact that if I make any inroad in dealing with the uninsured, it is to empower the individual with the wherewithal to cast a vote in the market place, which is the first step in billing a more rational market. The second stage is going to be more difficult, making that purchaser a knowledgeable purchaser. And that the hospitals aren't going to help me deal with the uninsured, some hospitals I should say, not a (inaudible). They aren't going to help me figure out what the average cost is, what the real cost is, what the cost plus a reasonable profit margin, and we can always debate profit margin, is going to be. Basically it was in our opinion that it's

the law and the regulation stemming from the laws that make us do what we do. And rightfully the Secretary came on very strong in the letter. I'm endorsing his letter and I'm doing more than that. I'm looking for partners in helping to solve the problem. Because to the degree that we can address reasonable charges to people, i.e. cost plus profit, and get a real market price down, you will assist yourself in terms of not having to go through some examination. But it will also assist us, as we move more to an individual market and we can collectivize the individual market in new and novel ways, and we don't have time to go into that today, to be able to make sure that someone who comes in and has their own wherewithal in a bank account at which they would like to pay a reasonable price out of their pocket to find out what the reasonable price is. Now, the other problem, of course, is what are they paying for? To what extent is what's on the bill the best possible choice they could have made had they'd been an informed consumer looking at alternatives especially measured by outcomes to create guidelines in terms of the way we deal with healthcare services associated with it. That's the next big step....