U.S. Senate Committee on Health, Education, Labor & Pensions
Hearing on
"How to Reduce Health Care Costs: Understanding the Cost of Health Care in America"

Testimony of Professor David A. Hyman
Georgetown University Law Center
dah137@georgetown.edu

How expensive is health care in the United States, and who pays? Why is American health care so expensive? And what should we do if we want to make health care in the United States less expensive? These three questions have provided steady employment to generations of health policy analysts – and resulted in piles of books, articles, governmental reports, white papers, op-eds, and blog postings.[1]

My testimony provides abbreviated responses to each of these questions, and highlights areas of agreement and disagreement. As detailed below, there is considerable agreement on the answer to the first question. There is more disagreement on the answer to the 2nd question -- and vehement disagreement on the answer to the 3rd question.

1. How Expensive is Health Care in the United States – and Who Pays?

One of the rare points of unanimity in American health policy is that the United States is "the most expensive place in the world to get sick."[2] Overall, we spent $3.3 trillion, or 17.9% of our GDP on health care in 2016.[3] Expressed in per capita terms, this is about $10.4k per person.[4] By way of comparison, the median household income in the United States is $59k.[5] By way of further comparison, American health care spending as a share of GDP is dramatically higher than any of our fellow OECD member countries.[6]

Polling indicates that high medical bills (and surprise bills) are a serious concern for many Americans.[7] Kaiser Health News and NPR have a website devoted to the "bill of the month," including a urine test that cost $17.8k, a prescription for toenail fungus that cost $1.5k.[8]

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[1] For my own recent contribution to the pile, see CHARLES SILVER & DAVID A. HYMAN, OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE (2018).
[2] Margot Sanger-Katz, Even Insured Can Face Crushing Medical Debt, Study Finds, N.Y. Times, Jan. 5, 2016, at https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html.
[3] CMS, National Health Expenditures Highlights, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf
[4] Id.
[5] U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States: 2016, Sep. 12, 2017, at https://www.census.gov/newsroom/press-releases/2017/income-povery.html.
[6] OECD, Health Expenditure and Financing, https://stats.oecd.org/Index.aspx?DataSetCode=SHA. According to the OECD, the U.S. spent 17.2% of GDP on health care in 2016. The next biggest spenders were Switzerland (12.4%), Germany (11.3%), and Sweden and France (11.0%).
[7] NORC, Americans' Views on Healthcare Costs, Coverage and Policy, Feb. 2018, at http://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf
[8] KHN, Bill of the Month, at https://khn.org/news/tag/bill-of-the-month/

Eric Ferguson of North Carolina was bitten by a snake and received a bill from his local hospital for $89k – most of which was for anti-venom that he found online for $3k.[9]

Of course, spending on health care varies widely, and a small share of the population accounts for a massively disproportionate share of total spending. For example, the top 5% of the population (in terms of health care spending) accounts for 51% of total health care spending, and the top 20% accounts for 83% of health care spending.[10] Conversely, the bottom 50% of the population (again in terms of health care spending) accounts for only about 3% of total health care spending.[11] Of course, among other things, age and health status affect health care spending.

Where does the money to pay for all this spending come from? The conventional approach is to differentiate between government-funded health care (principally Medicare, Medicaid, and CHIP); private insurance; and out-of-pocket. Over the past half-century, government's share has risen to roughly 45% of total health care spending, as new programs have been created and the populations covered by those programs have expanded.[12] These developments have created significant budgetary pressures, at both the state and federal levels. Conversely, the share of health care spending accounted for by out-of-pocket has declined dramatically.[13] Of course, these divisions are artificial: the funds to pay for government-funded health care are obtained by taxing individual households, and for most Americans, the premiums for employment-based insurance are foregone wages.

One final point: there is a difference between the absolute level of health care spending in the U.S. (which has been persistently higher than in all other countries) and the rate of health care spending growth (which slowed dramatically in the U.S. and in other countries beginning in 2008). It remains to be seen whether this slow-down (relative to historical averages) in growth rates is the new normal, or just a temporary pause. More to the point, strategies designed to target the absolute level of health care spending may do little about the rate of spending growth -- and vice-versa.

Why is American Health Care So Expensive?

The health care economy includes a daunting array of goods and services, delivered in a wide array of settings, by an army of professionals and allied health personnel. Each market niche has its own peculiar institutional details and compensation arrangements. But, at the highest level of generality, spending on health care in the United States equals the price per unit

[9] See Cato, Twice Bitten, at https://www.cato.org/multimedia/cato-video/twice-bitten. See also Ron Dicker, Eric Ferguson Charged More Than $89,000 By Hospital For Snake Bite Anti-Venom Treatment, Jan 31, 2014, at https://www.huffingtonpost.com/2014/01/31/eric-ferguson-snake-bite_n_4703157.html.
[10] Bradley Sawyer and Nolan Sroczynski, How do health expenditures vary across the population? Peterson-Kaiser Health System Tracker, Dec. 1, 2017, at https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#item-start.
[11] Id.
[12] For 2016 figures, see CMS, NHE Fact Sheet, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html
[13] ASPE Chartpack on National Health Spending, June 22, 2018, slides 8-9.

of service * volume of services. Thus, in examining why American health care is so expensive, it is necessary to consider both price and volume.

A solid body of research makes it clear that high prices are a major factor in why American health spending is so high. In the words of the conclusion of a well-known study published in Health Affairs in 2004:

> In 2000 the United States spent considerably more on health care than any other country, whether measured per capita or as a percentage of GDP. At the same time, most measures of aggregate utilization such as physician visits per capita and hospital days per capita were below the OECD median. Since spending is a product of both the goods and services used and their prices, this implies that much higher prices are paid in the United States than in other countries. But U.S. policymakers need to reflect on what Americans are getting for their greater health spending. They could conclude: It's the prices, stupid.[14]

A decade later, little had changed. That's when the late Uwe Reinhardt, one of the authors of the 2004 study, wrote a column entitled "U.S. Health Care Prices Are the Elephant in the Room."[15] A subsequent study, published in JAMA in 2018, used data from 2013-2016 for the U.S. and ten other high income OECD countries, and found that "prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries."[16]

To be sure, there are various complications, including a variety of volume/composition differentials that must also be taken into account. For example, in the United States we perform more imaging studies, Caesarean deliveries and knee replacements.[17] We also have higher administrative costs.[18] Many health care providers have the functional equivalent of a monopoly position, and price their products and services accordingly.[19] In many sectors of the health care economy, collusion and other anti-competitive practices are a persistent problem. Restrictions on entry further limit the effectiveness of competition. Finally, "decomposing differences in

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[14] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid": Why The United States Is So Different From Other Countries, 22 Health Affairs 89 (2004), at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.3.89.

[15] Uwe Reinhardt, U.S. Health Care Prices Are the Elephant in the Room, N.Y. Times Economix Blog, Mar. 29, 2013, at https://economix.blogs.nytimes.com/2013/03/29/u-s-health-care-prices-are-the-elephant-in-the-room/.

[16] Irene Papanicolas, Liana R. Woskie, Ashish K. Jha, Health Care Spending in the United States and Other High-Income Countries, JAMA. 2018;319(10):1024-1039, at https://jamanetwork.com/journals/jama/article-abstract/2674671.

[17] Ezekiel J. Emanuel, The Real Cost of the US Health Care System, JAMA. 2018;319(10):983-985, at https://jamanetwork.com/journals/jama/article-abstract/2674647.

[18] Id.

[19] Stephen T. Parente, Factors Contributing to Higher Health Care Spending in the United States Compared With Other High-Income Countries, JAMA. 2018;319(10):988-990, at https://jamanetwork.com/journals/jama/article-abstract/2674646.

health care spending into price and quantity is more difficult than it might seem, and there are important challenges in drawing policy inferences from such analyses."[20]

Viewed from a different perspective, the American health care system is expensive because every incentive points in that direction. Our reliance on open-ended third-party payment seems designed to funnel money from the rest of the economy into the health care system. In health care, we have relatively few constraints – whether on the supply-side or on the demand-side, and whether on price or on volume. Previous attempts to impose such restraints have predictably given rise to cries of "rationing," followed by lobbying and lawsuits. The consequences are easy to see.

Finally, there is tremendous waste, fraud, and abuse in our health care system. Knowledgeable observers believe that something on the order of one-third of dollars spent on health care are wasted. In 2011, Berwick and Hackbarth offered a mid-point estimate of the cost of waste of $910 billion, with an upper bound of $1.263 trillion.[21] A different team of researchers reached a similar conclusion in 2015.[22] In my forthcoming book, we found evidence of waste, fraud, and abuse everywhere we looked.[23]

What Should We Do if We Want to Make American Health Care Less Expensive?

Open-ended third-party payment has given us a health care system we can't afford. If we don't like things the way they are, we need to change the incentives under which our health care system operates. OVERCHARGED is full of ideas on how to do that. A partial list would include the following:

- Encourage market entry, particularly by lower-cost providers.
- Rely more heavily on first party payment.
- Subsidize those in need by giving them money, rather than open-ended insurance.
- Minimize mandated benefits.
- Increase competition in the market for generic drugs with (i) increased antitrust enforcement; (ii) priority review of ANDAs for generic drugs that have experienced price hikes, (iii) prevent misuse of the FDA's processes to slow generic entry; and (iv) relax the FDA's grip on entry by allowing companies that qualify to sell generic drugs in Canada, England, France, Israel, and other developed countries to sell the same drugs in the United States — at least so long as a generic equivalent has already been approved by the FDA, and the 180 days of marketing exclusivity provided by the Hatch-Waxman Act has expired.
- Move as many drugs as possible from Medicare Part B to Medicare Part D.

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[20] Katherine Baicker & Amitabh Chandra, Challenges in Understanding Differences in Health Care Spending Between the United States and Other High-Income Countries, JAMA. 2018;319(10):986-987, at https://jamanetwork.com/journals/jama/article-abstract/2674648.

[21] Donald M. Berwick & Andrew D. Hackbarth, Eliminating Waste in US Health Care, JAMA. 2012;307(14):1513-1516, at https://jamanetwork.com/journals/jama/article-abstract/1148376.

[22] Paul Keckley, Medical Necessity and Unnecessary Care – The Full Story, The Keckley Report, Jan. 26, 2015, at http://www.paulkeckley.com/the-keckley-report/2015/1/26/medical-necessity-and-unnecessary-care-the-full-story.

[23] See *supra* note 1.

- Eliminate the requirement that Medicare Part D plans cover all approved drugs in the six "protected classes": immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.
- Move as many drugs as possible from prescription-only to over-the-counter, or behind-the-counter.
- Adopt strict payment neutrality regardless of the site in which care is delivered.
- Adopt competitive bidding for Medicare Advantage.
- Use prizes (rather than patents) to encourage drug innovation.
- Improve transparency of information on pricing and quality.
- Address charge-master abuse by enforcing basic contract law principles. Failing that, cap out-of-network bills at Medicare's payment rate + a modest percentage.

Reasonable people can disagree about the optimal strategy for making our health care system more affordable. And different people will prefer different trade-offs among cost, quality, and access. But, everyone should understand that our current trajectory is unsustainable.