"How to Reduce Health Care Costs: Understanding the Cost of Health Care in America"

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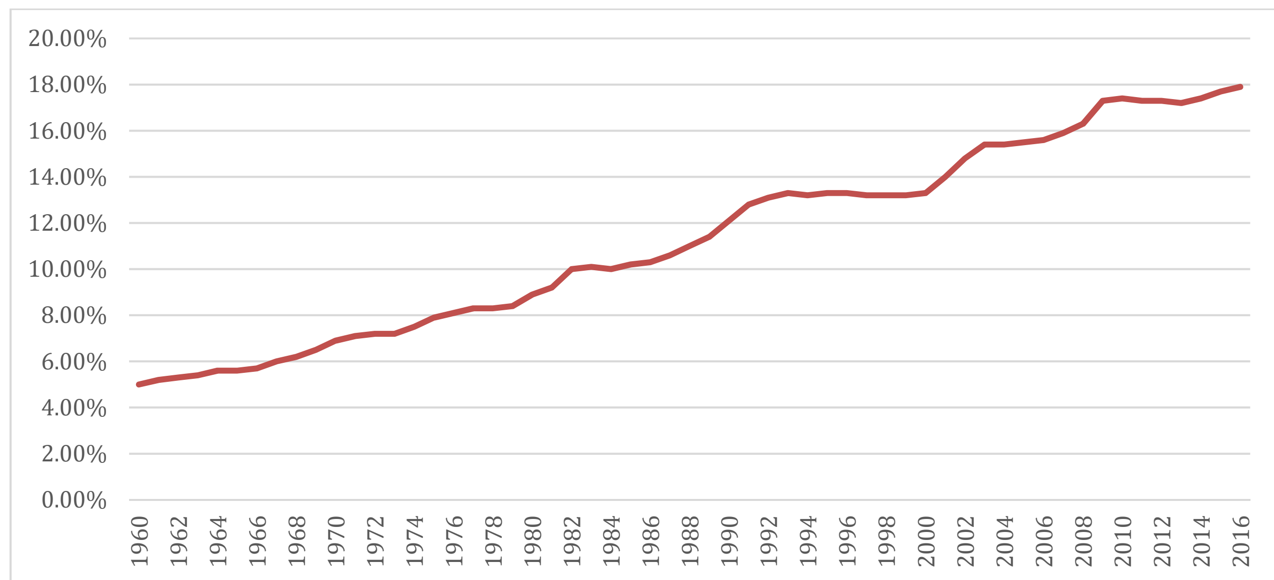
Chairman Alexander, Ranking Member Murray, members of the Committee, I'd like to thank you for the opportunity to testify today on "How to Reduce Health Care Costs: Understanding the Cost of Health Care in America." I'm honored to speak about this issue, which may be the most important social policy challenge facing our nation.

While our political leaders often disagree on many economic and social issues, there is unique bipartisan agreement that U.S. health care spending is too high, and fails to deliver value for money. This represents not only a major policy challenge, but also an opportunity. And while the cost of inaction is being felt in communities across our great nation, the dividends, if we get smarter about managing health care spending, will also be felt by every single American.

THE PROBLEM

Today, U.S. health care spending accounts for approximately 18 percent of gross domestic product (GDP). In addition, spending on health care has outpaced overall economic growth in the U.S. for more than 5 decades.

Figure 1: U.S. Health Care Spending as % of GDP



Source: Kaiser Family Foundation

This leads to a number of important challenges that currently face the country. First and foremost, the cost of health care to American families has significantly outpaced wage growth. From 2001 to 2016, the cost of health insurance for a family of four grew from $8,414 to $25,826[1] - a ~200% increase, compared to a ~40% growth in median household income over the same time period.[2]

[1] Milliman Medical Index, 2001-2016.
[2] U.S. Census Bureau, "Income and Poverty in the United States." Note: this is unadjusted for inflation.

Second, expenditure on health care represents a growing burden for government at all levels. Indeed, many people describe the U.S. federal government as a large health insurance company with the world's greatest military.[3] Everything else the federal government does can feel like a rounding error.

States and local governments across the nation are struggling with the growing costs of health care for their employees and retirees, and states are spending more and more of their budget on Medicaid. All put together, government agencies are spending so much on health care that it leaves very little money for other priorities, such as roads and bridges, public health, policing, and education, to name just a few. The Federal government, of course, isn't immune here either. The Medicare program accounts for a growing share of taxpayer dollars. While some of this growth is due to more seniors aging into the program, per beneficiary costs are still expected to grow faster than the overall economy over the next 10 years.[4]

Third, this is not just a public sector issue; 85% of the American workforce is employed by the private sector. High health care costs limit businesses' flexibility in structuring compensation for their employees, making it difficult to remain competitive in an increasingly global marketplace. This is why the legendary investor, Warren Buffet, calls health care spending in our country a tapeworm that sucks the nutrients out of American business. Even two decades ago, Ford Motor Company reported that they spent more on health care than they did on steel.[5] This is typical of many companies that are labor intensive, where the high costs of health care makes hiring people expensive, putting pressure on companies to automate further, with often devastating effects on communities that are reliant on those jobs.

Over the years, there have been numerous policy efforts that have tried to address the growth in health care spending. However, as this hearing highlights, we have not made adequate progress. And I believe that the ACA, despite good intentions, had little impact either in a positive or negative direction on the underlying drivers of health care spending.[6] And it's time to get serious about tackling health care spending.

International Context

Is health care spending really too high? I hope my comments above lay out clearly how our health care spending is having negative impact on individuals, businesses, and government. But it's also worth comparing ourselves to other advanced economies, such as Switzerland, UK, and Germany, because examining their systems can help us better understand what drives our high health care costs.

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[3] This is often attributed to Peter Fisher, former undersecretary of the treasury in 2002. See http://economistsview.typepad.com/economistsview/2013/01/who-first-said-the-us-is-an-insurance-company-with-an-army.html.

[4] Table V.D1 in "2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

[5] Hirsch S. "GM Plant a Sign of Decline." *The Baltimore Sun.* May 9, 2005. http://www.baltimoresun.com/business/bal-te.bz.gm09may09-story.html

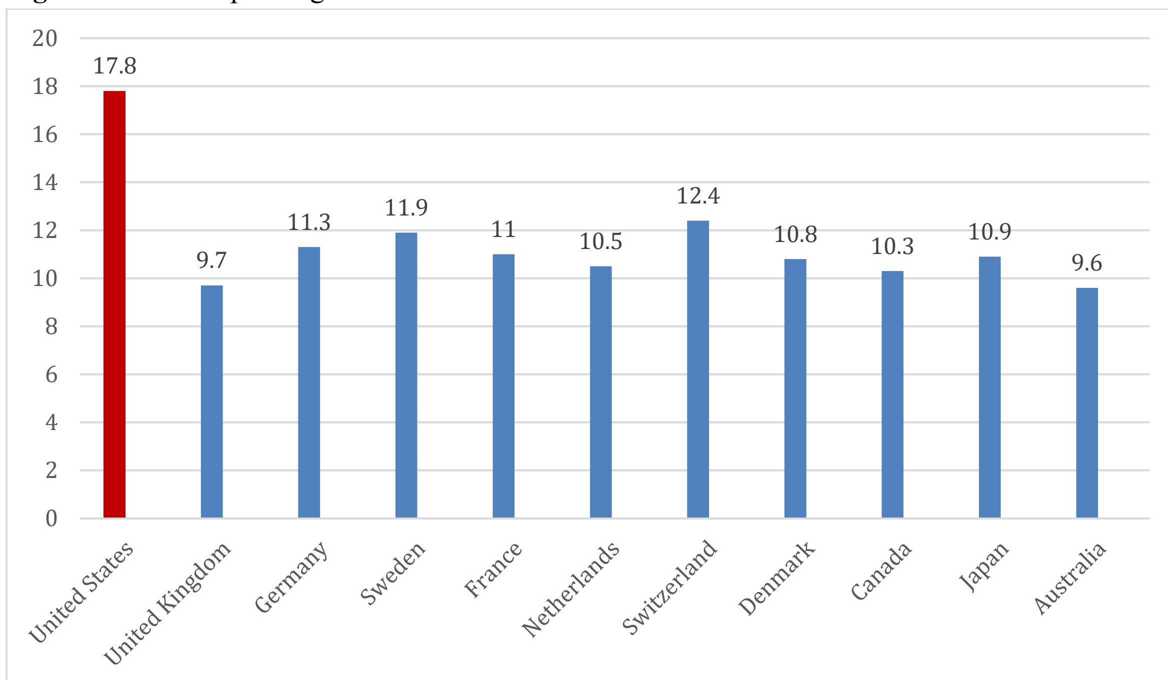
[6] Weiner J, Marks C, and Pauly M. "Effects of the ACA on Health Care Cost Containment." Leonard Davis Institute of Health Economics. March 2, 2017. https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment

To be clear, I do not believe that any country that I have examined has the perfect health care system. Nor do I believe that we can wholesale adopt another nation's health care system and overnight make our system function better.

But, careful examination of other high income countries' health systems can help us better identify why we spend so much on health care and what we might do to create a uniquely American solution to tackling health care costs.

First, let's cover some basics. There is no doubt about it, we spend a lot more on health care than anyone else. Here is our spending compared to those of other, select high income countries. Indeed, viewed alongside our peer nations, our problem looks even worse.

Figure 2: Health Spending as % of GDP in OECD Countries



Source: Papanicolas I, Woskie LR, Jha AK. Health Care Spending in the United States and Other High-Income Countries. JAMA. 2018;319(10):1024–1039.

At nearly 18 percent of GDP, the U.S. outspends its OECD counterparts by a large margin. On a per-capita basis, the U.S. spends nearly *twice* the average comparable OECD country. Switzerland is a very expensive high income country and is the second biggest spender on health care (after the U.S.). If the U.S. spent, on a per capita basis, what Switzerland spends we would save $974 billion per year. That's nearly a trillion dollars every year, more than if our spending level matched Switzerland.

While U.S. health care spending is clearly very high, a reasonable question might be whether we are getting good value for the money. Here too, the story is not great (though it's also not all bleak). We have

among the lowest life expectancies of any advanced nation.[7] We have exceptionally high rates of maternal and infant mortality.[7] On so many population level outcomes, we lag behind. Our health care system has not focused on managing those issues.

The story here is not without hope. On some key outcomes, the U.S. is a true global leader. While we have more heart attacks, per population, than most other advanced countries – when Americans do have heart attacks, they are more likely to survive than people who have heart attacks in other industrialized countries. The same is true for stroke. We have superb acute care – and we deploy the latest technology in ways that have a tremendous impact on people's lives.

Another area where we are leaders is in innovation. Our funding model – and our high prices (see more on this below) is the innovation engine of the world. We create more new tests and therapies – whether they are drugs, devices, or innovative procedures – than any other country in the world. And others around the world, of course, benefit from those innovations.

And finally, I believe that we have some of the best-trained doctors and nurses in the world. Our health care professionals are second to none in their knowledge, professionalism, and dedication to caring for our people.

These are all strengths that should be preserved. But even taking these strengths into account, I believe that the takeaway here is simple: our health care system fails to deliver for the needs of the American people – and given how much we spend, we need to do better.

But how? Today, I will address some common beliefs about why our health care system is so expensive and share with you what the evidence and data tell us.

MYTHS & REALITIES

There is no shortage of theories for why health care spending is so much higher in the U.S. than in other advanced nations. Let's address some of the most common explanations.

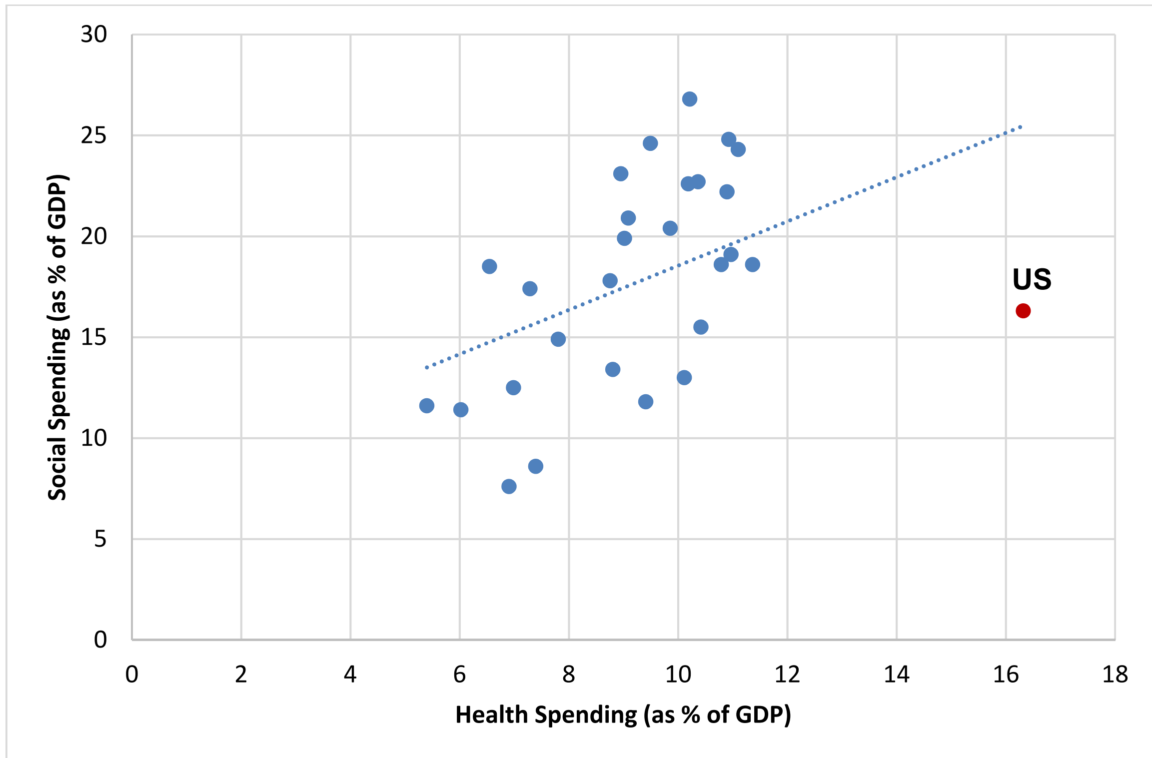
Myth 1: Social Spending

Some critics of the U.S. health care system have argued that our high health care spending is driven by under-investments in beneficial social spending. It is true that, on average, the U.S. spends less[8] on social services – pensions and social programs like food stamps – than many other advanced nations. The theory here is simple: under-investment in social services leads to a sicker population that uses more health care and that drives high health care spending. On the face of it, the story seems reasonable – one might imagine that there is a tradeoff between social spending and health care spending.

[7] Papanicolas I, Woskie LR, Jha AK. Health Care Spending in the United States and Other High-Income Countries. *JAMA*. 2018;319(10):1024–1039.
[8] Bradley EH, Elkins BR, Herrin J, et al Health and social services expenditures: associations with health outcomes *BMJ Qual Saf.* 2011;20:826-831.

However, beyond the theory, careful examination of the data suggests otherwise.

Figure 3: Social Spending & Health Expenditures as & of GDP in OECD



Source: 2014, OECD Social Expenditure Database

This figure makes several points clear.

First – the U.S. doesn't actually spend that much less than other OECD countries on social expenditures (16.3 percent versus a mean of 17.8 percent for 28 OECD countries, excluding Mexico and Poland due to missing data).

Second, there appears to be a positive relationship between social and health care spending. Indeed, the data does not support the idea of a tradeoff between social spending and health care spending (i.e. that somehow, if countries spend more on social spending, it will lead to lower health care spending).

Finally if the story I outline above – that lack of social spending is leading to more sick people who use more health care, we should see much higher rates of health care utilization. Yet, as I lay out below, that's not what we see.

It is worth making one point clear. I do believe that targeted, well-administered social spending, such as social security for the elderly and aid to families, can be of enormous value in improving health care outcomes. The data suggest it won't somehow save us enough money in health care to pay for itself.

Myth 2: Utilization

A second, common explanation for our high health care spending is the argument that we have much higher rates of utilization than other high income countries. These critics argue that whether it is for cultural reasons (i.e. Americans are quick to go to the doctor) or defensive medicine (our malpractice system drives doctors to admit people to the hospital unnecessarily, for instance), Americans are using a lot more health care than people in other high income countries. Unfortunately for these critics, the data say otherwise.

Americans in fact have:[7]

- Fewer doctor visits than our international peers (U.S.: 4 per capita; OECD Mean: 6.6 per capita)
- Fewer hip replacements (U.S.: 204 per 100,000; OECD Mean: 207 per 100,000)
- Fewer hospital discharges (U.S.: 125 per 1,000; OECD Mean: 149 per 1,000)
- And much shorter hospital stays (U.S.: 5.5 days; OECD Mean: 7.6 days)
- We *do* perform slightly more hysterectomies (U.S.: 266 per 100,000 females; OECD Mean: 225 per 100,000 females)
- Comparable number of knee replacements (U.S.: 226 per 100,000; OECD Mean: 263 per 100,000)
- And many more MRI scans (U.S.: 118 per 1,000; OECD Mean: 82 per 100,000)

On many measures of health care utilization, we are below average. On many other measures of health care utilization, we are above average. And that leads, in my opinion, to only one reasonable conclusion: when it comes to health care utilization, on average, the U.S. is about average.

Neither culture nor a deficit of social spending seems to be driving Americans to the doctor's office significantly more often than their peers.

Myth 3: Over-Specialization

A final myth concerns the mix of specialists and primary care physicians practicing in the U.S. We all know that a visit with a specialist is generally much more expensive than a visit with a primary care doctor. Could overuse of specialist services account for U.S. health care costs?

As with overuse more generally, this hypothesis also seems to be at odds with the data.

When it comes to the total number of physicians in the country, the U.S. actually has fewer doctors, per capita, than the OECD average (2.6 per 1,000 people in the U.S. versus 3.3 per 1,000 people in the OECD).

But don't we lack primary care physicians and have too many specialists? I do believe that in many communities, we lack enough primary care physicians. But seen as a nation, our mix of primary care and specialists is about average across high income countries.

We estimate, relying on data from the Kaiser Family Foundation and surveys from the American Medical Association, that about 57% of physicians in the U.S. are specialists. That's just about average across a

group of other high income countries where we were able to get comparable data. The story is similar when it comes to nurses, with the U.S. just below the OECD average (11.1 per 1,000 vs 11.8 per 1,000).[7]

Once again, for such an expensive system, our number and mix of doctors and nurses looks remarkably similar to those in other countries.

REALITIES

So what actually does explain the difference in cost? The answers are in many ways less complicated than these explanations suggest.

Reality 1: Administrative Complexity

The first major contributor to health care costs is administrative spending and complexity. The U.S. has a highly fragmented system of insurers, with around half of spending coming from private sources and the rest from public sources. With 880 insurers, American health care billing requires physicians' offices, hospitals, and other providers to maintain myriad different forms and manage different sets of benefits with varying risks of claim denial.

Some research has put all of the time and effort and resources that go into running our health care system to be as high as 30 percent of the total health care spending.[9] This is a very aggressive figure and likely overstates administrative costs. That said, there is no doubt that our administrative inefficiencies are costing us a lot of money.

When using a simple, narrow definition of what it costs to administer our health care system, the OECD found that 8% of our health care spending goes to administrative costs. Most other high income countries, including those that are primarily private, spend less than half that.[10]

Switzerland and the Netherlands, for instance, which also rely on private insurers, have a substantially lower administrative burden than the U.S.

Reality 2: It's The Prices

The second and most important factor that explains why our spending is so much higher is straightforward: it's the prices. The U.S. has, across the board, the highest prices for medical goods, services, and labor across all OECD countries. Crestor, a cholesterol-lowering drug, costs $86 in the U.S., more than twice the OECD average. This general pattern holds true for nearly all brand-name drugs.

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[9] Jiwani A, Himmelstein D, Woolhandler S, Kahn JG. Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence. *BMC Health Services Research.* 2014;14(556).
[10] OECD Health Expenditure Database.

But these price differences persist not just in pharmaceuticals. Primary care physicians are paid, on average, $218,000 in the U.S. versus $133,000 among other advanced nations; CT scans cost more than double, as do MRIs, colonoscopies, and various other procedures.[11]

A recent example illustrates the price problem most acutely: Prince Louis, the latest "royal baby" born to Kate Middleton, the Dutchess of Cambridge, was delivered in what The Economist described as a "luxurious private maternity ward in London."[12] The cost of a luxurious private maternity ward in the middle of London (a very expensive city)? $8,900. The average cost of delivering a normal, healthy baby in the U.S.? The Economist estimated it at $10,800, though in many communities the cost is much, much higher. So when the royal baby in a luxurious private maternity ward in London is much cheaper than the average birth in the U.S., we have a price problem.

High prices need to be understood in the context of what that price buys. Obviously, one would never compares a Cadillac to a Nissan and say that they are both cars and the only meaningful difference is their prices. And in some instances, our higher prices do mean we get the latest medical devices and medicines more quickly, and our physicians and nurses, among the best paid health professionals in the world, are also among the best.

But for many things, we aren't getting meaningfully higher quality – the MRI machines in London and Geneva are every bit as good as those in Nashville or Boston, but we are paying two or three times as much. Here, the analogy is not between a Cadillac and a Nissan – but between a red corvette and a blue one. We may prefer the red corvette – but as a country, we are paying twice as much as others do for their blue one. Same car.

SOLUTIONS

So what can we do about this? In its current state, the U.S. health care market is deeply dysfunctional. A lack of reliable prices and price transparency, abuse of market power by dominant incumbents, and a hopelessly complicated bureaucracy all contribute to this untenable status quo. Many countries manage their price problems through a strong government price setter. We know efficient markets are another way to manage prices. We have managed to do the worst of both – we have a weak price setter in Medicare and we have largely dysfunctional markets.

If we are to create uniquely American solutions, I believe we need to do three things. Each of them is politically feasible and has generally enjoyed bipartisan support. Together, I believe these ideas can make a real impact on the health care system. My recommendations to the committee are as follows:

1) Bring real price transparency to health care markets

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[11] International Federation of Health Plans 2015 Comparative Price Report.

[12] "A typical American birth costs as much as delivering a royal baby." *The Economist.* April 23, 2018. https://www.economist.com/graphic-detail/2018/04/23/a-typical-american-birth-costs-as-much-as-delivering-a-royal-baby

2) Support the Federal Trade Commission and the Department of Justice to help enforce our antitrust laws
3) Support efforts that will help improve administrative efficiency

Solution 1: Price Transparency

In a market-oriented health care system, price transparency is essential. No market can function without it. We would never expect to go shopping where the prices weren't available (and we received an undecipherable bill a month later). In the same way, price transparency is an essential element.

More than 60 million Americans are now in a high-deductible health plan. That means that they are paying for a substantial part of their health care out-of-pocket before their insurance kicks in. Yet, for most of these individuals (and I am one of them), the lack of price transparency means one can't be a smart shopper. For most consumers, it is nearly impossible to get the price of even simple, predictable services, such as an MRI or an elective procedure. Worse yet, our deeply broken system means that even when patients think they are going to an in-network hospital, some physicians will bill "out-of-network" in ways that leave patients with very large, unexpected bills.[13] We would never tolerate this kind of deceptive behavior in any other industry, and yet we let it continue in health care.

We have some evidence on price transparency and that evidence is largely encouraging. When the California Public Employees' Retirement System (CalPERS) implemented a so-called reference-based pricing mechanism to pay for hip and knee replacements, patients were told that the plan would pay a specific amount for the procedure. If a patient went to a more expensive provider, they would have to pay the difference. Patients responded to the combined incentives well: the combination of value-based insurance design and clear, binding price estimates encourages patients to seek out the low-cost providers. On top of that, high-cost providers began reducing their prices in response.[14]

A similar experience has been seen with All-Payer Claims Databases (ACPDs) – state databases that collect data on prices paid by insurers. APCD data is used by researchers like myself, but it has also been used by payers in negotiations. In New Hampshire, for instance, a large insurer, realizing that their rates were substantially higher, used APCD data to negotiate better rates.[15] Unfortunately, the utility of APCDs has been stymied by a recent Supreme Court decision (in *Gobeille v Liberty Mutual)* to allow some employers to opt out of APCDs.[16]

To help inject greater price transparency into U.S. health care markets I recommend the following:

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[13] Cooper Z, Scott Morton FM, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. *National Bureau of Economic Research*. Working Paper No. 23623 (2017).
[14] Robinson JC, Brown TT. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. *Health Affairs.* 2013; 32(8):1392-1397.
[15] Kutscher B. "How New Hampshire took the guesswork out of health care costs." *Modern Health care*. July 16, 2015. http://www.modernhealth care.com/article/20150716/NEWS/150719922
[16] Feyman Y and Frakt A. "Supreme Court delivers a blow to health care cost transparency." *STAT*. March 4, 2016. https://www.statnews.com/2016/03/04/health-care-cost-transparency/

1) Require that, as a condition of participation in the Medicare program, providers and hospitals need to be able to provide any patient with a binding cost estimate (that allows for rare exceptions) to patients prior to receiving a service.
    a) In instances where emergency room-related charges are considered out-of-network, require that the patient's out-of-pocket requirement be capped at in-network rates.
    b) Require that if the hospital is in-network, any physician who works in that hospital has to accept in-network rates

    Some of these changes will require federal action and others, state action.

2) Encourage the creation and use of APCDs, by clarifying that ERISA's preemption of self-insured employer regulation does not extend to data collection by state-run APCDs.

3) Experiment, through the Center for Medicare & Medicaid Innovation (CMMI), with modifying Medicare's benefit structure to implement approaches like reference-based pricing that encourage price transparency among providers.

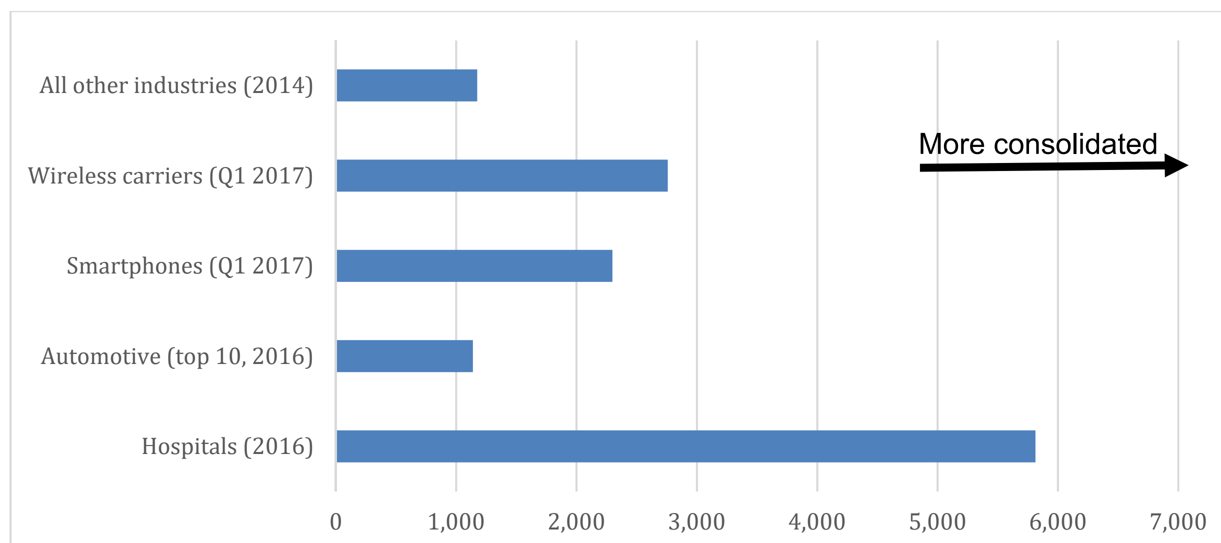
Solution 2: Ensure competition

The lack of price transparency in the American health care system is bolstered by a set of largely non-competitive markets, which are becoming even less competitive over time. This is a particularly acute problem in the hospital sector (which accounts for one-third of American health care spending), where recent data suggests that the average hospital market is already highly-concentrated based on Federal Trade Commission (FTC) thresholds.[17] Merger activity has been steadily on the rise. In 2017, for instance, there were 115 hospital mergers, the highest number since 2000.[18] A small share of hospital mergers are typically large enough to be reported to the FTC (less than one-third were reported in 2014), and among these, a small sliver even make it to a preliminary investigation. This has resulted in 90 percent of metropolitan hospital markets now qualifying as "highly-concentrated" based on FTC thresholds.

Figure 4: Average Herfindahl-Hirschman Index (HHI) By Industry

[17] Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Affairs.* 2017; 36(9):1530-1538.

[18] "2017 in Review: The Year M&A Shook the Health care Landscape." Kaufman Hall. https://www.kaufmanhall.com/sites/default/files/2017-in-Review_The-Year-that-Shook-Health care.pdf



Source: Authors' calculations; Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Affairs*. 2017; 36(9):1530-1538; Grullon et al. "Are US Industries Becoming More Concentrated?" October 2016.

Based on both fundamental economic theory and a very substantial evidence base[19], we know that less competitive markets have both higher prices and lower quality. The evidence on this is unequivocal. Yet, the FTC is too severely understaffed to review or investigate most of these mergers and therefore, has to usually let them go through. And the cost of those mergers is enormous to American taxpayers. Inadequate funding of our agencies that ensure a vibrant and healthy marketplace may be the biggest example of being penny wise, pound foolish.

There is no reason to believe that this trend towards greater consolidation is about to slow down. Hospitals are now acquiring more physician practices and the data here seems to suggest that when they do, prices in those markets go up.[20]

The increasingly monopolistic structure of U.S. hospital markets makes pro-competitive policy an immediate priority. To do so, I recommend the following:

1) Encourage greater scrutiny for mergers by lowering the threshold for pre-merger notification. This is critical for maintaining competition.
2) Increase funding for staff at the FTC and DOJ to review, investigate, and where appropriate, challenge mergers that are likely to be anti-competitive and harmful to consumers.
3) Encourage the FTC to develop more rigorous approaches to evaluate vertical mergers, particularly in health care.

[19] Gaynor M and Town R. "The Impact of Hospital Consolidation." Robert Wood Johnson Foundation. June 1, 2012. https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[20] Post B, Buchmueller T, Ryan A. Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality. *Med Care Res Rev*. 2017.

Solution 3: Administrative Simplification

While evidence on the importance of antitrust and price transparency is clear, we know less about which approaches will be most useful in lowering wasteful administrative spending. It is also worth noting that not all administrative costs are wasteful. A bank can lower its administrative costs by getting rid of its security guards, but we would never claim that spending on security is a wasteful administrative cost of running a bank. In the same way, some administrative costs in health care, like fraud-fighting and smart benefit design administration, are important and beneficial. Medicaid, for instance, which has a much higher claims denial and review rate than Medicare, spends close to 5 percent of total spending on administrative costs.[21]

Nor is the private sector the only culprit. Even countries with systems that rely more on private insurance, such as Switzerland and the Netherlands, tend to have lower administrative costs. Administrative costs are a feature of the U.S. health system because it is a fragmented system.

Other countries have a number of solutions to address this issue. However, it is unclear the extent to which these solutions are a fit for the U.S. To that end, I recommend the following:

1) Direct administrative costs
    a) Streamline as many processes as possible across insurers, such as provider credentialing, by implementing a national program for credentialing providers that all payers will be required to accept.
2) Indirect administrative costs (e.g. labor)
    a) Address physician, and other care providers', time spent on billing. By simplifying administrative burdens, providers spend less time and money on dealing with different billing/reporting systems and more time with patients.
3) Explore additional approaches to further reduce the administrative burden in the U.S.

CONCLUSION

U.S. health care spending has been, and still is, on an unsustainable trajectory, a trend even more apparent when we examine the performance of our peers. The three broad approaches I have discussed – ensure price transparency, promote competition, and simplify administrative burdens – would address the underlying factors driving our high and unsustainable health care spending. Each of these should be able to garner broad, bipartisan support – largely because as Americans, most of us believe in the power of transparency, competition, and reducing the burden of bureaucracy. These are achievable goals and if we move in these directions, we can ensure a more vibrant, efficient health care system that places less of a burden on us and future generations.

[21] MACPAC Data Book 2017, Exhibit 31. https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-31.-Total-Medicaid-Administrative-Spending-by-State-and-Category-FY-2016-millions.pdf