

**HOW TO REDUCE HEALTH CARE COSTS:
UNDERSTANDING THE COST OF
HEALTH CARE IN AMERICA**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING HOW TO REDUCE HEALTH CARE COSTS, FOCUSING ON
UNDERSTANDING THE COST OF HEALTH CARE IN AMERICA

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**HOW TO REDUCE HEALTH CARE COSTS:
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HEALTH CARE IN AMERICA**

Wednesday, June 27, 2018

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m. in room SD-430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Enzi, Isakson, Collins, Cassidy, Young, Murkowski, Scott, Murray, Casey, Murphy, Kaine, Smith, and Jones.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Senator Murray and I will each have an opening statement, and then I will introduce the witnesses. Then we will hear from the witnesses, and the Senators will each have about 5 minutes to ask questions.

For the last 7 years, Republicans and Democrats have been locked in a debate about health insurance. Primarily, the individual insurance market, which is important, but it is where only 6 percent of insured Americans get their health insurance.

But the hard truth is we will never get the cost of health insurance down until we get the cost of health care down.

Today, we are beginning a series looking at how to reduce health care costs, including examining administrative costs, waste, how to improve transparency, private sector solutions, and other important issues as they come up.

According to the World Bank, the United States produces 24 percent of all the world's wealth for just 5 percent of the people who live here.

According to the Centers for Medicare and Medicaid Services, in 2016, we spent 17.9 percent of our wealth, our Gross Domestic Product, on health care. And CMS projects that share will rise to nearly 20 percent by 2026.

The United States spends a significantly higher percentage of our GDP on health care than other countries. However, I expect several witnesses here today will say we should be cautious about how we compare the United States' economy to other countries around the world when we are discussing health care costs.

According to the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, which is the Health Data Office at HHS, we spent \$2.2 trillion on health care in 2006. That is projected to grow to \$5.7 trillion in 2026. That is a 159 percent increase.

Warren Buffet has called the ballooning costs of health care, quote, “A hungry tapeworm on the American economy.”

What does this mean for families, and for businesses, and for taxpayers?

According to the HHS Health Data Office, in 2016, American families spent an average of \$1,095 per person on their health care, up from \$705 a person in 2000, not including insurance premiums.

Most people do not even know what they are paying because medical bills are so confusing.

In 2016, according to HHS Health Data Office, private businesses and employees paid for over half the \$3.3 trillion we spend on health care, which is money that is going to increasing health care costs instead of paychecks and bank accounts.

According to the Congressional Budget Office, American taxpayers spend more on health care programs than anything else, including our national defense and the National Institutes of Health.

The first step to reducing health care costs is to better understand the cost of health care in America and understand why health care in America costs so much more than it costs in other countries.

The most obvious fact about health care costs, other than that they are too high, is that they are often indecipherable. Any one of us who has received a hospital bill in the mail or has tried to figure out their health insurance benefits has wondered what it all means.

The complexity of the health care system, not only means it is difficult to determine what is driving up the costs, but this complexity itself is driving up the cost of health care.

Over the last 18 months, the HELP Committee has had hearings on four different areas of health care spending:

One, the cost of prescriptions drugs; why is the cost paid by patients rising and what can Congress do to help? We saw the complexity of the health care system in the list price and rebate process, which seems to benefit everyone but the consumer.

Two, wellness programs; there is a consensus, and we heard about it, that a healthy lifestyle helps people live longer and better lives, and reduces health care costs.

Three, the 340B Drug Pricing Program; according to researchers at New York University, Harvard, and the “New England Journal of Medicine,” the 340B Drug Pricing Program incentivizes consolidation in the health care industry, which reduces competition and drives up costs.

Four, Electronic Health Records; the Federal Government has spent over \$38 billion incentivizing the adoption of Electronic Health Records to help share data, improve care, and reduce costs only to find that Electronic Health Records do not work very well, add tremendous administrative burden to doctors, and are expensive to maintain and update.

Now, the Committee is going to focus on ways to reduce health care costs and before we come up with solutions, we want to understand the drivers of health care spending.

Who is spending all this money on health care? What is the money being spent on? When in a person's life do they spend money on health care? Where does the money go?

According to the HHS Data Office, 31 percent of the \$3.3 trillion we spent on health care in 2016 was for care in hospitals. Twenty percent was spent on physician and clinical services; 5 percent on nursing care and home health; and 10 percent for prescription drugs that we pick up at the pharmacy.

But according to witnesses at our drug pricing hearing, the percent we spend on prescription drugs is closer to 17 percent when we account for prescription drugs given in a setting such as a hospital or a nursing facility.

The average American is shocked by the cost of health care. They do not understand what they are being charged for, and why it costs so much, and they want better answers. We hope to find those answers.

That is what I heard from Todd, a Knoxville, Tennessee father who recently took his son to an emergency room after a bicycle accident. Todd paid the \$150 co-pay, because the emergency room was in network for his health insurance, and they headed home.

Todd was surprised when he received a bill for \$1,800 because even though the emergency room was "in network," the doctor who treated his son was not.

Todd wrote me trying to find out why it is so hard to understand what health care really costs and said, "If I am expected to be a conscientious consumer of my own health care needs, I need a little more help."

Well, maybe we can provide a little more help for Todd, individuals like him, employers, and other taxpayers as we take the first step toward reducing health care costs by understanding health care costs better.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you, Mr. Chairman.

Before I begin, I do want to note that I am still very deeply concerned about the Administration's cruel and chaotic policies that have now caused thousands of children to be separated from their parents with no apparent plan for reunification.

We had a positive step yesterday with the injunction ordering children to be quickly reunited with their parents. But no matter how this plays out in the courts, we need answers about how these kids are going to be cared for, when they are going to be reunited with their families, what the future holds for those in similar situations going forward, and more.

It is just unacceptable. It is inexcusable and we do not have answers to those straightforward questions yet. So we are going to keep asking the Administration, pushing them to give us, and separated families, some clear answers.

Now, we are here today to discuss how to reduce health care costs, which is something I hear constantly when I am home in my

state. I know other families across the country feel the same way, so I am very interested today in what our witnesses have to say about this issue. I want to thank all of you for coming and joining us today.

There are far too many stories about patients caught off guard by health care bills higher than they expected and concerned that they will not be able to afford the care they need. Patients like LeeAnn Tiede from my home State of Washington.

After getting treatment for breast cancer, which she checked to be sure her insurance would cover, she was surprised to get a bill for nearly \$800. Her hospital was in the network. Her surgeon was in the network. The anesthesiologist was not. So her insurance stuck her with most of the bill. And her story is not unique.

Patients in Washington State, and across the country, have also experienced this so-called “balance billing” after learning providers were not in their insurance network. And her story is only part of the problem.

People are not just concerned about the cost of a surprise bill from providers who are out of network, they are concerned about the skyrocketing price of drugs, and they are concerned about the cost of rising insurance premiums. These are challenges that impact families every single day, and they are challenges President Trump promised time and again to address on the campaign trail.

Unfortunately, it is difficult to imagine what else President Trump could possibly be doing to make these challenges worse. Since day one, he has not only failed to rein in prescription drug prices, but has brought chaos, uncertainty, and higher costs to health care in this country across the board.

He tried again and again to jam the Trumpcare bill through Congress, and when he could not do that, he chose to create Trumpcare by sabotaging patients’ care in every way he could, including:

Doing just about everything possible to gut protections for people with preexisting conditions;

Slashing investments in helping people get care and shortening enrollment windows;

Making it easier for insurers to sell junk plans;

Championing tax cuts for massive corporations paid for by policies that his own former Health Secretary said would raise premiums, and more.

All of this sabotage has translated, according to independent analysis, to higher costs for so many patients. And this has not just impacted the health care marketplaces that were created under the Affordable Care Act.

President Trump’s efforts to undermine protections for people with preexisting conditions could leave millions of people, who are currently uninsured, without the ability to afford the care they need.

He has sabotaged innovative efforts at lowering costs across the health care system. Instead of supporting sensible programs to bundle payments that encourage providers to keep costs down and deliver the best results for patients, President Trump delayed those programs and ultimately canceled some of them.

He left an important laboratory for experimenting with new, affordable, and high quality models for delivering care—the Centers

for Medicaid and Medicare Innovation—without a director for a full year.

Undermining opportunities to discover new cost-lowering innovations not only jeopardizes bipartisan reforms to contain costs that we secured in 2015, but also perpetuates the premium increases and financial burdens patients are now facing thanks to the President's health care sabotage.

As I have said before, all of this is especially frustrating because it did not have to be this way. I continue to be deeply disappointed that the Republican leaders refuse to support the bipartisan agreement that this Committee agreed on months ago, which could have lowered premiums for this year, and next, and helped stabilize markets.

As I have said, Mr. Chairman, I am still at the table if and when Republicans are ready to resume those negotiations.

Now, as I said, there are a number of ideas that could help bend the curve over the long term as we begin to explore in the Affordable Care Act. I mentioned a few earlier, and I am similarly very interested in how Accountable Care Organizations can reduce costs by rewarding providers for good patient outcomes, rather than racking up charges.

I am also proud that Washington State has helped lead the way with innovative new programs like the Medicaid Transformation Demonstration, which is designed to better coordinate care and help keep patients healthy in the first place. I am looking forward to discussing these and other targeted approaches to lowering health costs.

But at the same time, I want to be clear. We cannot talk about higher health care costs in our country without acknowledging the elephant in the room, which is that President Trump has dramatically increased them.

What is desperately needed in the near term is for Republican leaders to set aside tired, partisan political fights over health care. Allow us to work together on the kinds of policies we were all able to agree on just months ago that could have made a significant difference for families nationwide.

Democrats have wanted to do this work for years. We got close this past year. I am confident we can still succeed if we work across the aisle and put patients and families first.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

We will now welcome our witnesses. Each witness will have up to 5 minutes to give his or her testimony. I am pleased to welcome them.

The first is Dr. Melinda Buntin. She is Professor and Chair of the Department of Health Policy at Vanderbilt University School of Medicine.

Prior to this, she served as Deputy Assistant Director for Health at the Congressional Budget Office, where she was responsible for managing and directing studies of health care and health care financing issues in the Health Retirement and Long Term Analysis Division.

The second witness is Dr. Ashish Jha. He is the K. T. Li Professor of Global Health at Harvard University, Senior Associate

Dean for Research, Translation, and Global Strategy at Harvard T. H. Chan School of Public Health, and the Director of the Harvard Global Health Initiative.

He is a general internist and also Professor of Medicine at Harvard Medical School, a member of the Institute of Medicine at the National Academies. We welcome you, sir.

Third, we will hear from Mr. Niall Brennan, President and Executive Director of the Health Care Cost Institute. Prior to that, he was Chief Data Officer at the Centers for Medicare and Medicaid Services and he served on the Medicaid-Medicare Payment Advisory Commission, MedPAC, and in the Congressional Budget Office.

Last, we will hear from Dr. David Hyman. Dr. Hyman is a Law Professor at Georgetown University School of Law. He focuses on health care regulations, civil procedure, insurance, medical malpractice, law and economics, professional responsibility, and tax policy.

He is an Adjunct Scholar at the Kato Institute and he led the first joint report on health care and competition between the Department of Justice and the Federal Trade Commission while Special Counsel at the FTC.

Welcome, again, to all of our witnesses.

Dr. Buntin, let us begin with you. If each of you could summarize your remarks in about 5 minutes, we have a number of Senators who then would like to have a conversation with you.

Dr. Buntin.

STATEMENT OF MELINDA BUNTIN, PH.D., MIKE CURB PROFESSOR AND CHAIR, DEPARTMENT OF HEALTH POLICY, VANDERBILT UNIVERSITY SCHOOL OF MEDICINE, NASHVILLE, TENNESSEE

Dr. BUNTIN. Good morning.

I would like to thank Chairman Alexander, Ranking Member Murray, and the other Members of this Committee for giving me the opportunity to speak about how we can address the high and rising cost of health care in the United States.

My name is Melinda Buntin and I am a health economist and the Mike Curb Professor of Health Policy at Vanderbilt School of Medicine.

This testimony is derived, in part, from recent academic work with colleagues at Vanderbilt, and from earlier work with colleagues at the Congressional Budget Office, and RAND.

The amount that we spend on health care in the United States is high; \$3.3 trillion per year. That works out to more than \$10,000 for every man, woman, and child in this country. As a result, health care accounts for a large fraction of our total national output.

We currently devote almost 18 percent of our GDP to health care, meaning almost \$1 out every \$5 spent in our economy is spent on some form of health care.

Yet, despite this high overall level of spending, I would urge Members of this Committee to focus on reducing the rate of growth in per capita health care costs. Let me explain why.

The \$3.3 trillion we are currently spending reflects the incomes of the millions of people employed by the health care industry and the revenue of thousands of hospitals, medical offices, and pharmacies across the country. It is very hard to reduce that level of spending despite the burden it places on households.

Turning to overall spending growth, that reflects both changes in the number and types of people covered—for example, the increasing number of people over age 65 covered by Medicare—and changes in the costs of their care.

If we put aside for the moment the separate issue of the numbers of people covered, attention to per capita cost growth isolates the cost of care and it underscores the types of policy choices that drive changes in the trajectory of health care costs.

One clear example of this can be found in the recent history of the Medicare program. Overall, Medicare spending has grown because large numbers of Baby Boomers are becoming eligible for the program as they turn age 65.

But per capita cost growth in the Medicare program has been low over the past decade, even after adjusting for the fact that the average beneficiary is younger.

There are three main reasons for this.

First, policy choices have kept growth and Medicare payments low. Examples of these policy choices include physician payment rate changes under MACRA, and the hospital productivity adjustments under the ACA.

Second, there have been changes in the rate of growth of new health care technologies and in the use of health care services. In particular, there has been a reduction on a per capita basis in the use of care in expensive inpatient settings.

I would note, though, that a countervailing trend, and one that is expected to intensify, has been an increase in high cost drug treatments and regimens.

Then third, the emphasis on value-based care has contributed to providers' paying closer attention to their cost structures and their investments. This can be expected to influence cost growth in the future if providers believe that public and private insurers are serious about paying for value.

What, then, are the policy options that Congress can and might consider to ensure that we get the most from what we spend on health care?

There are three areas that merit attention from policymakers, in my view.

First, this Committee should be commended for its investigations of innovative ways to make sure that drugs are affordable and appropriately utilized. I know you have already held many hearings on that subject.

Second, ongoing vigilance about price increases is warranted. Medicare payment rates, for example, are important in their own right and they are important because they are often a starting point for negotiations between providers and insurers. They also set the benchmarks for value-based payment reforms.

In addition, given the rate of mergers and consolidations in our health care industry, history and empirical research have shown us that we should be concerned about future price increases.

Third, continued focus on value-based payment methods like the payment for episodes or bundles of care that Senator Murray mentioned, instead of payment for individual services, will encourage providers to seek out technologies that can improve health and contain costs.

In sum, for all the health care costs in this country, and the burden it places on our governments and families, we do have one of the most advanced health care systems in the world, albeit one that does not serve all of our citizens equally well.

We have hospitals that employ thousands of people in communities across the country and nearly every day brings stories of medical breakthroughs. In other words, our costs are also cures, jobs, and incomes.

Given this, and based on the data I have seen and the research I have done, continuing to focus on stemming growth in per capita costs through creating the right incentives for health care suppliers and providers is the most promising way to ensure that we get more value out of our health care dollars.

Thank you very much.

[The prepared statement of Dr. Buntin follows:]

PREPARED STATEMENT OF MELINDA J. B. BUNTIN

I would like to thank Chairman Alexander and Ranking Member Murray for giving me the opportunity to speak today about how we can address the high costs of health care in the United States. My name is Melinda Buntin, and I am the Mike Curb Professor of Health Policy in the Department of Health Policy at the Vanderbilt University School of Medicine. This testimony is derived in part from recent academic work with colleagues at Vanderbilt and from earlier work done while I was at the Congressional Budget Office and RAND.

Problem Statement

The amount that we spend on health care in the United States is high—\$3.3 trillion dollars per year. That works out to more than ten thousand dollars for every man, woman, and child in the country. As a result, health care accounts for a large fraction of our total national output, or GDP. We currently devote 18 percent of our GDP to health care—almost one dollar out of every five spent in our economy is spent on some form of health care. Many households devote an even greater share to health care. Consider, for example, the Milliman Medical Index, which captures the average costs of a typical employer-sponsored plan for a family of four. It was over \$28,000 in 2017, which is roughly equivalent to the wages of two full-time workers at the Federal minimum wage.¹ This level of expenditure is a major reason that the wages of American workers have stagnated. It is also a reason why employers have been slow to hire full-time workers as we have grown out of the recession.² This level of spending also puts a high burden on our working population to support benefits for older, disabled, and poor citizens who depend on Medicare and Medicaid.

Yet despite these high spending levels, in this testimony I will argue that it is not overall dollar amounts, or that proportion of GDP *per se*, that is a problem. Instead, I will argue that it is per capita cost growth that is the most important factor to watch. Per capita growth gives the clearest indicator of the growing cost of care delivery and the changes in our health care system.³ Trends in per capita costs also underscore that policy choices we have made and can make in the future do drive changes in health care delivery. In fact, per capita cost growth in the Medicare pro-

¹ Note that this figure does not include the cost of administration or insurer profits. <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf>.

² David I. Auerbach, Arthur L. Kellermann. "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family." *Health Affairs*, v. 30, no. 9, Sep. 2011, p. 1620–1636.

³ Per capita costs would ideally be adjusted for changes in the age and health status distribution of the population in questions as well. See <https://www.healthaffairs.org/doi/10.1377/hblog20150728.049597/full/>.

gram has been low over the past decade and examining those trends provides some concrete examples of how cost growth might be kept in check.

What drives what we spend on health care?

To think about how policy choices might affect the levels of and growth in health care spending, it is important to understand the components of health care costs and what drive them. These vary by payer, whether that payer is Medicare, Medicaid, or private insurance.

First, there is the **number of people covered**. Overall Medicare and Medicaid spending have grown rapidly over the past decade primarily because of growth in the number of people covered. Medicare has grown because of the aging of the baby boomer generation and the increases in life expectancy for Americans at older ages. Medicaid rolls grew during the recession, by design, and grew due to expansions in coverage under the Affordable Care Act. Whether or not the current rules for Medicaid eligibility are too lenient or too stringent is the subject of debate but can be separated from debates about the costs of insurance. Private insurance coverage levels vary with conditions in the labor market and have been climbing slightly in recent years.⁴

Total spending is the number of people covered times the **cost per person** of coverage. The cost per person for coverage is determined by the numbers of health care products and services used and the prices paid for those services—plus insurer costs for administration and profit. Those in turn are determined by factors that economists group into supply side and demand-side factors.

The **numbers of products and services used** are dependent on the supply of those services and how accessible they are. We have millions of people employed by the health care industry and thousands of hospitals, medical offices, and pharmacies across the country. This infrastructure of professionals and providers is built around a health care financing system in which, by and large, providing more services brings in more revenue. To counter incentives to deliver more services, managed care plans put prior authorization requirements in place. Increasingly, however, insurers are using payment methods and quality measurement to encourage the delivery of high-value care and discourage overutilization of low-value care.

On the **demand side**, there are also clearly interactions between the prices of health care products and services, and how many products and services people use. People with insurance are insulated from the full prices of care but do face deductibles and cost-sharing requirements. The approximately 10 percent of the population who are **uninsured** also use health care services, financed largely through patient out-of-pocket payments and Federal and state programs that support hospitals, community health centers, and other providers. Overall, the uninsured use fewer services than those with insurance,⁵ and when they do use health care services some providers charge on a sliding scale and sometimes pay higher prices because they pay the “list price” rather than a price negotiated by an insurer. Changes in the prices faced by patients, either because of what is charged or how generous their insurance is, affect demand for insurance and for care. Demand-side factors also include how healthy or sick people and populations are, and how much they can afford to spend on health care.

Growth in health care spending is thus fueled by growth in numbers of people served, numbers of products and services on offer, the prices paid for those services, and how much demand there is for them. It is also fueled by expectations about all of those factors, because those expectations drive investments in facilities and in research and development of new technologies. Indeed, health economists generally attribute about half of growth in health care spending in the United States to the growth of new technologies.⁶

It is also important to mention the commonly accepted figure that about 30 percent of what we spend on health care is **waste**—or expenditure that brings little

⁴ https://www.cdc.gov/nchs/data/nhis/earlyrelease/TrendHealthInsurance1968_2016.pdf.

⁵ Katherine Baicker, Ph.D., Sarah L. Taubman, Sc.D., Heidi L. Allen, Ph.D., Mira Bernstein, Ph.D., Jonathan H. Gruber, Ph.D., Joseph P. Newhouse, Ph.D., Eric C. Schneider, M.D., Bill J. Wright, Ph.D., Alan M. Zaslavsky, Ph.D., and Amy N. Finkelstein, Ph.D. for the Oregon Health Study Group. “*The Oregon Experiment—Effects of Medicaid on Clinical Outcomes.*” *N Engl J Med* 2013; 368:1713–1722.

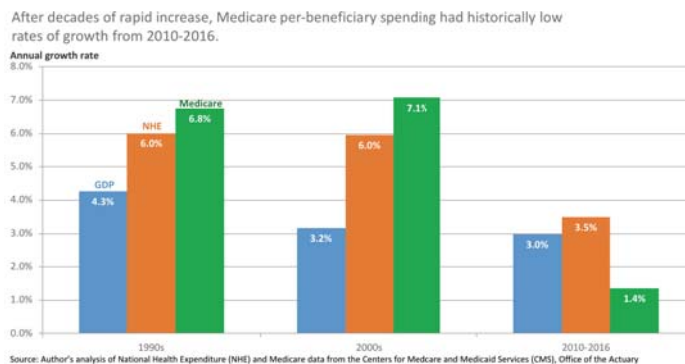
⁶ Newhouse JP. An iconoclastic view of health cost containment. *Health Aff (Millwood)*. 1993; 12 Suppl:152–71.

or no benefit to patients.⁷ While this is an enormous sum, there is little consensus on how to define waste in practice and even less on how to substantially reduce it. What seems more fruitful is to focus on the health care system features that give rise to such a wasteful set of structures for delivering health care.

Accordingly, health economists, including my colleagues at the Congressional Budget Office, often focus on “**excess cost growth**” rather than spending levels when talking about the sustainability of health care spending. Excess cost growth is growth in per capita health care costs above growth in per capita GDP. In other words, it is growth in health care costs that outpaces the ability of our society to pay for it. Arguably, as high as spending is, our society is paying for the health care system we have now and recent projections of GDP growth for next year are strong. Of concern is whether the lower rates of health care cost growth in recent years can be sustained while the economy grows overall.

Low Spending Growth in Medicare

As mentioned above, the recent decade of low per capita cost growth in the Medicare program is an instructive example. From 2007 to 2015, total Medicare expenditures increased 50 percent, but much of this growth was due to the number of Medicare beneficiaries covered. Indeed, on a per capita basis, Medicare spending has been lower than per-capita GDP growth from 2010–2016. The figure below puts this in context: Medicare per capita spending growth has been low both in relation to prior decades and to national health spending overall.



The figure shows that average annual growth in Medicare per capita spending was 1.4 percent between 2010 and 2016, down from 7.1 percent between 2000 and 2010, due in part to reductions in payments to providers and plans and to an influx of younger beneficiaries from the baby boom generation aging on to Medicare (who have lower per capita health care costs.)⁸ According to the 2018 Medicare Trustees Report, Medicare per capita spending is projected to grow at an average annual rate of 4.6 percent over the next 10 years.⁹ The trustees project this level of growth due to their forecasts of increased use of services, intensity of care, and rising health care prices—but those factors are affected by policy choices. If choices are made that keep Medicare per capita spending growth below the rate of GDP growth, that will relieve spending pressure on the Federal Government and have implications for private payers as well.

The **volume**—or number—of health care services delivered to Medicare beneficiaries has also been relatively flat. Indeed, according to figures from MedPAC, the volume of inpatient hospital services has declined: inpatient discharges per bene-

⁷ Smith M, Saunders R, Stuckhardt L, McGinnis JM, eds. Committee on the Learning Health Care System in America, Institute of Medicine. Washington, DC: National Academies Press; 2012. ISBN: 9780309260732.

⁸ Juliette Cubanski and Tricia Neuman. *The Facts on Medicare Spending and Financing*. KFF, June 2018.

⁹ 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds accessible at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>.

fiary declined almost 20 percent between 2006 and 2015.¹⁰ Some of that decline was due to a shift from inpatient to outpatient care settings, but the decline still represents a decline in the amount paid for such services. And, unlike in prior periods of time, new inpatient technologies didn't replace those moving to the outpatient sector. Indeed, when my colleagues and I adjusted per capita Medicare costs for payment rate increases we found that they have been relatively flat since 2007, indicating that use of care per beneficiary has been similarly stable. These low rates of growth in the use of health care services, and especially inpatient services, have been found in the private sector as well.¹¹

In work I did while at the Congressional Budget and have since updated, my colleagues and I also found that slow growth in **Medicare payment rates** contributed to the slowdown in per capita cost growth.¹² We found that prices have increased more rapidly in private insurance than in Medicare for inpatient, outpatient, and physician services. The exception to this pattern has been drugs—both Medicare Parts B and D have seen years of dramatic growth in spending and spending per prescription—for example around the introduction of the very expensive drugs for hepatitis C. The amount allocated to Medicare Advantage (MA) has also increased, but that reflects the increased enrollment in Medicare Advantage plans: prices paid to providers by MA plans track Medicare prices because of a rule that allows MA insurers to pay out-of-network providers at the Medicare rate.¹³

What accounts for the slow growth in Medicare? While academics debate the portion of the credit that should go to each factor and how they should be grouped, there is general agreement that the following factors collectively explain the slowdown in spending growth.

- *Changes to Medicare payment rates:* Sequestration, the slow growth in physician payments and the temporary freezing of physician payment rates under MACRA, and the Medicare hospital productivity adjustments have all contributed directly to lower spending and slower spending growth. Prices paid by private insurers have risen more.
- *Changes to Medicare's payment methods:* The Congress and CMS have both signaled a strong interest in moving toward more risk-based and value-based payments for providers under Medicare. While individual payment demonstration projects have yielded only modest savings, if any, the orientation toward value has driven changes in alignment and investment by providers.
- *Changes on the consumer/demand side:* Although cost-sharing requirements have been very stable in Medicare, Americans have become more exposed to health care costs overall and new retirees may have had experience with high-deductible plans that leads them to be more cautious users of health care services. In addition, while the levels are still high and growing, the rate at which Americans are developing chronic diseases appears to have attenuated somewhat, which helps to keep health cost growth down.

These lessons learned from Medicare's experience can inform policy choices that might prolong the cost growth slowdown and be applied to other sectors.

Addressing the Drivers of Health Spending

What then are policy options that the Congress can and should consider to ensure that we get the most from what we spend on health care—and that health spending does not crowd out more valuable goods and services? There are three areas, looking forward, that merit attention from policymakers.

1. Seek innovative ways to make sure that drugs are affordable and appropriately utilized.

The Committee has had numerous hearings on the issues of drug development and pricing and has heard ideas from experts in these areas. As new specialty drugs are projected to be a major driver of cost increases in the

¹⁰ MedPAC 2017 Data Book. http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0.

¹¹ HCCI 2016 Cost and Utilization Report accessible at https://drive.google.com/file/d/1vi3S2pjThLFVwB7OtYwFmOiLVPTFl_wk/view.

¹² Michael Levine and Melinda Buntin. "Why Has Growth in Spending for Fee-for-Service Medicare Slowed?" Congressional Budget Office Working Paper. August 2013.

¹³ Jared Lane K. Maeda Ph.D., MPH, Lyle Nelson, Ph.D.. *How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare With Medicare Fee-for-Service Prices? Inquiry*. First Published June 11, 2018.

future, it is important to ensure they are accessible to patients but targeted only to those likely to benefit from them. Signals about future prices and value standards will influence the drugs developed and the prices at which they are brought to market. The utilization of medicines for managing chronic diseases is also important and could contribute to offsetting lower medical service costs.¹⁴

2. Continue vigilance on payment rates.

Congress, with the help of MedPAC, has a rigorous system for evaluating Medicare payment rate increases. MedPAC has begun to focus on the costs of efficient providers—rather than the average provider—in making recommendations about payment rates. This is an important development, as payment rates benchmarked to standards of efficiency should create incentives to invest in cost-saving technologies and operational procedures. It is also important as most private payments are benchmarked to Medicare rates.

In addition, research has consistently shown that provider consolidation in the health care industry raises prices. Congress should monitor merger and consolidation trends in the health care industry and support more research to better understand how to mitigate those effects.

3. Continue to advance value-based payment methods including episodes/bundles and more comprehensive risk-bearing models.

It is important that the Federal Government continue to pilot new payment models and to expand the models found to save money without compromising quality. This sends a strong signal to the health care industry that it should invest in information systems, care coordination initiatives, and a population health orientation. The Federal Government should also support multi-payer payment reforms because they are more likely to reduce spending over the long term than reforms implemented by one sector and it should continue to develop better methods of measuring quality of care.

On the consumer demand side, I am less optimistic about opportunities to contain cost growth without doing harm. While work I conducted with colleagues at RAND suggests that high-deductible health plans can reduce health care spending, the effects are attenuated by accounts like HSAs. We also found evidence that consumers cut back on investments in preventive care when faced with high deductibles (even when preventive care is exempt from deductibles and cost-sharing.)¹⁵ Subsequent work has confirmed these findings, and found that price transparency tools did not improve the care choices of high-deductible plan enrollees.¹⁶ Given this, and the high levels of health care expense already borne by Americans, efforts focused on the suppliers of health care are more likely to attenuate cost growth without adversely affecting health outcomes.

For all of the concern about health care costs, we do have one of the most advanced health care systems in the world, albeit one that does not serve all citizens equally well. We have gleaming hospitals that employ thousands of people in communities across the country, and nearly every day brings stories of medical breakthroughs like immunotherapy. In other words, our costs are also cures, jobs, and incomes—and thus stemming their growth is not without challenges and costs of its own.

[SUMMARY STATEMENT OF MELINDA J. B. BUNTIN, PH.D.]

The amount that we spend on health care in the United States is high—\$3.3 trillion dollars per year. That works out to more than ten thousand dollars for every man, woman, and child in the country. Yet despite these high spending levels, per capita cost growth that is the most important factor to watch. Per capita growth gives the clearest indicator of the growing cost of care delivery and the changes in our health care system. Trends in per capita costs also underscore that policy

¹⁴ Melinda Buntin and Tamara Hayford. *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services*. CBO Report. November 2012.

¹⁵ Melinda B. Buntin, Ph.D.; Amelia M. Haviland, Ph.D.; Roland McDevitt, Ph.D.; and Neeraj Sood, Ph.D. "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans." *Am J Manag Care*. 2011;17(3):222–230.

¹⁶ Brot-Goldberg, Zarek, Amitabh Chandra, Benjamin R. Handel, Jonathan T. Kolstad, 2017. "What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*," *The Quarterly Journal of Economics*, vol 132(3), pages 1261–1318.

choices we have made and can make in the future do drive changes in health care delivery.

In fact, per capita cost growth in the Medicare program has been low over the past decade and examining those trends provides some concrete examples of how cost growth might be kept in check. Specifically, policies that have kept growth in Medicare payment rates low and an emphasis on value-based care have contributed to slow cost growth on a per capita basis.

What then are policy options that the Congress can and should consider to ensure that we get the most from what we spend on health care—and that health spending does not crowd out more valuable goods and services? There are three areas, looking forward, that merit attention from policymakers.

1. Innovative ways to make sure that drugs are affordable and appropriately utilized.
2. Continued vigilance on payment rates.
3. Continued focus on value-based payment methods including episodes/bundles and more comprehensive risk-bearing models.

For all of the concern about health care costs, we do have one of the most advanced health care systems in the world, albeit one that does not serve all citizens equally well. We have gleaming hospitals that employ thousands of people in communities across the country, and nearly every day brings stories of medical breakthroughs like immunotherapy. In other words, our costs are also cures, jobs, and incomes—and thus stemming their growth is not without challenges and costs of its own. Focusing on stemming growth in per capita costs through creating the right incentives for health care suppliers and providers is the best way to ensure we get maximal value out of our health care dollars.

The CHAIRMAN. Thank you, Dr. Buntin.
Dr. Jha, welcome.

STATEMENT OF ASHISH JHA, M.D., M.P.H., DIRECTOR, HARVARD GLOBAL HEALTH INSTITUTE, K. T. LI PROFESSOR AND SENIOR ASSOCIATE DEAN, HARVARD T. H. CHAN SCHOOL OF PUBLIC HEALTH, AND PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, CAMBRIDGE, MASSACHUSETTS

Dr. JHA. Good morning, Chairman Alexander, Ranking Member Murray, and Senators.

Thank you for having me here. It is a privilege to be here.

I want to talk about something that Senator Alexander brought up, which is, we spend about twice as much on health care as other high income countries do. And while we have known that for quite a while, I believe that the critics of our health care system have gotten the diagnosis wrong of why it is that we spend so much more than other countries.

One of the things I learned early in medical school is if you get the diagnosis wrong, it is really hard to come up with the right treatment.

Let us talk about what the diagnosis, I believe, has been and what I think the truth is based on data that we have gathered that has emerged more recently, and think about what that means for improving the efficiency of our health care system.

The popular belief has been that the reason we spend so much more on health care than other countries is that we just use too much health care. Maybe it is American culture. Maybe it is defensive medicine. Whatever the explanation, the belief has been that Americans just use a lot more health care.

Well, it turns out when you look at the data, when you compare us to citizens of other advanced nations like Germany, and France,

and Canada, and Switzerland, when you compare us to those countries, it turns out, Americans see the doctor a little less often than people in those countries do. We spend fewer days in the hospital than those countries do. When it comes to tests and procedures, we do more of some and less of others.

When you look at the big picture on the issue of utilization, how much health care do we actually use, the way I think about it is we are above average on some things, we are below average on other things, and on average, we are pretty average. We are not using that much more health care than what citizens of other countries are using.

If we are not using more health care, why is it, as Senator Alexander said, why is it we are spending twice as much?

There are two reasons. One, is administrative complexity. We spend a lot more money on administrative costs than other countries. Now, this is not a public or private issue. Even countries like the Netherlands and Switzerland, which have a primarily private insurance scheme, spend a lot less than we do.

It is possible to get administrative efficiencies in public systems and in private systems.

But the big 800 pound gorilla in the room around health care spending, and what differentiates us from other countries is, price. Every time we use health care in America, we pay a lot more than any other country in the world.

We have spent, as a country, quite a bit of time, and this Committee has led so much of the work, thinking about drug prices and appropriately so. But yes, we pay a lot more for drugs. We also pay a lot more for MRI's. We pay more when we have an appendectomy. We pay more when we have cardiac surgery.

Every single thing that happens in health care in America, we pay twice, three times more than what other countries are paying. And that is a problem that we have not addressed wholly.

Let us think about how we might address those issues, and I have three suggestions. The first two are, I think, intricately linked.

One is price transparency. Now, we talk about price transparency, both Senator Murray and Senator Alexander brought that up.

The bottom line is right now, you can be in the health care market any place, pick Nashville, Seattle, you can get your MRI in one place. You cross the street to another, and you might end up paying twice as much. But nobody knows because the prices are not clear to people. One step in improving the efficiency of our system is to make prices much more transparent.

But I think what you will hear from all of us is that alone is not going to do very much. There are a couple of reasons.

One is that it is very hard for consumers to engage and get the true price that they will pay. Generic prices are not useful. What is useful is, "How much am I going to pay?"

The second thing that is really critical in all of this is competition because the bottom line is imagine a place where somebody is selling slices of pizza for \$10. You can make that price transparent, but if you do not have an alternative to go somewhere else for a

cheaper slice of pizza, price transparency is not going to do you much.

You need competition. You need alternatives. When we look at the health care industry, what we find is across the board, it is far more consolidate. There is far less competition than there is in almost any other industry in America. And that is a problem.

Mergers and acquisitions have continued unabated. The agencies that are supposed to protect us from monopoly power, the Federal Trade Commission, the DOJ, have been understaffed. You can see it in the fact that they review a very small proportion of the mergers, and they block almost none of them.

The signal to the marketplace is clear: mergers, acquisitions, get more market power, get higher prices. The Federal Government is not going to stop you. That, I think, has been a major issue in keeping prices high and keeping our health care spending high.

Finally, I believe there is a lot we can do on administrative simplification. The bottom line is that there is a series of ideas for things that will not hurt innovation, will not hurt quality that we can do while ensuring that there is uniform credentialing across insurance products. It is how insurance companies file their claims.

There is a bunch of stuff that is in the kind of back office that can make a big difference and can save us tens, if not hundreds of billions of dollars over time. So openness and transparency, competition, simplification.

One thing you learn from doing international work is that there is no one solution. Every country arrives at its own solution. I think those three principles are part of a uniquely American solution to improving the efficiency of our health care system.

Thank you.

[The prepared statement of Dr. Jha follows:]

PREPARED STATEMENT OF DR. ASHISH K. JHA

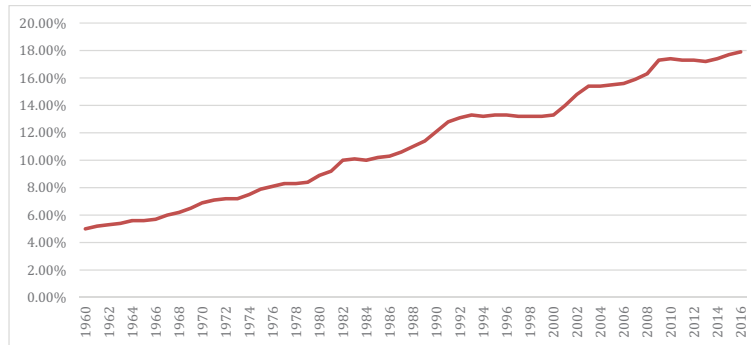
Chairman Alexander, Ranking Member Murray, Members of the Committee, I'd like to thank you for the opportunity to testify today on "How to Reduce Health Care Costs: Understanding the Cost of Health Care in America." I'm honored to speak about this issue, which may be the most important social policy 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 percent 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 \$25,826¹—approximately a 200 percent increase, compared to an approximate 40 percent growth in median household income over the same time period.²

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 percent 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

¹ Milliman Medical Index, 2001–2016.

² U.S. Census Bureau, "Income and Poverty in the United States." Note: this is unadjusted for inflation.

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>.

of health care spending.⁶ And it's time to get serious about tackling health care spending.

International Context

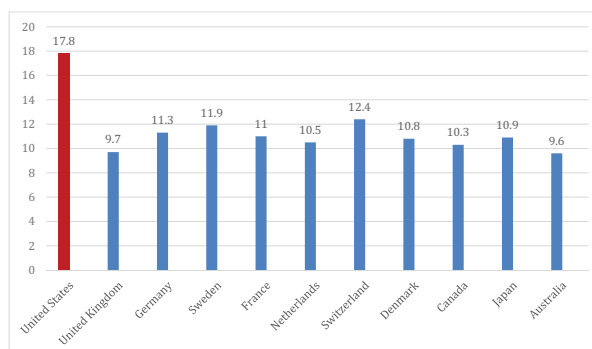
Is health care spending really too high? I hope my comments above lay out clearly how our health care spending is having negative impact on individuals, businesses, and government. But it's also worth comparing ourselves to other advanced economies, such as Switzerland, UK, and Germany, because examining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

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 percent 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. 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.

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>.

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.

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.

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

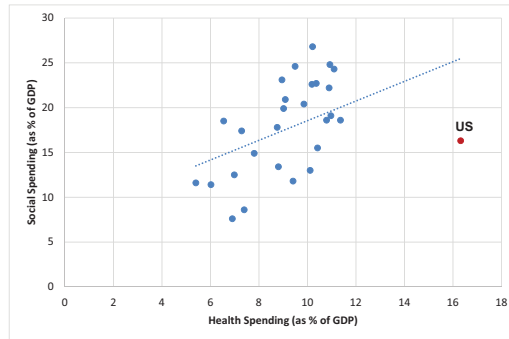
There is no shortage of theories for why health care spending is so much higher in the U.S. than in other advanced nations. Let's address some of the most common explanations.

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 less⁸ 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.

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

Figure 3: Social Spending and Health Expenditures as and 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).

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.

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:

- 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)
- 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)
- 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 percent 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).

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

REALITIES

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 percent 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.

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 Duchess 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 compare 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

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 an-

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 Data base.

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>.

other 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.
- (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 Data bases (APCDs)—state data bases 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:

- (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.

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/>.

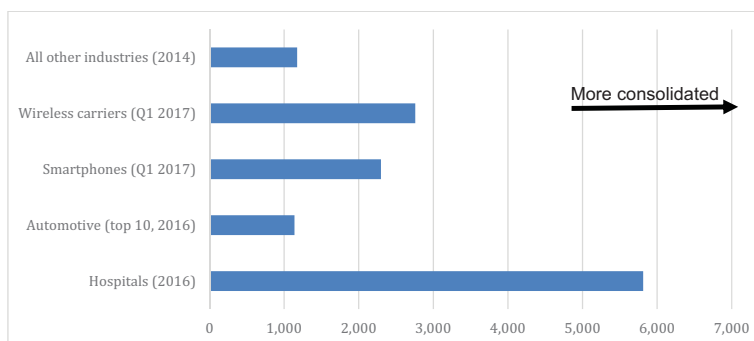
(2) Encourage the creation and use of APCDs, by clarifying that ERISA’s preemption of self-insured employer regulation does not extend to data collection by state-run APCDs.

(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



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 base¹⁹, 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 toward 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

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.

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.

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.

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.

[SUMMARY STATEMENT OF ASHISH K. JHA]

The Problem: American health care spending—at 18 percent of GDP—is out-of-line with overall economic growth and does not deliver outcomes commensurate with this level of spending.

The International Context: U.S. health care spending is well above that of other high income countries. Comparable OECD countries spend 11.5

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>.

percent of their GDP on healthcare; when compared to peers, we do not get good value for the money we spend.

Myths: There are several myths that persist about the underlying cause of this discrepancy:

- **Myth 1—Social Spending:** The U.S. spends less on social programs (such as food stamps) relative to health care than its peer nations. This has led some to suggest that this underinvestment results in unnecessary health care use due to preventable illnesses. This doesn't appear to be an adequate explanation given that the U.S. doesn't spend substantially less on social spending as a *share of GDP* than its peers (16.3 percent vs 17.1 percent).
- **Myth 2—Utilization:** Another oft-cited explanation is that Americans simply have a culture of over-use and use health care services more liberally. With fewer doctor visits, hip replacements, hospital discharges, this too doesn't offer a helpful explanation.
- **Myth 3—Overspecialization:** One myth posits that the U.S. has more specialist physicians who provide the same care at higher cost. It turns out that with specialists accounting for 57 percent of all physicians, this story simply lacks support in the data.

Realities: With a careful look at the data, we find that the following actually drive U.S. spending:

- **Reality 1—Administrative Complexity:** The U.S. *does* appear to spend significantly more than peer countries on administration—8 percent versus 3 percent in comparable OECD countries. Moreover, some analyses have found that nearly one-third of U.S. health care spending is billing-related administrative burden.
- **Reality 2—Prices:** The second factor explaining the massive disparity is simply the price of goods and services. This is true across all labor, goods, and services—including drugs, physician salaries, and most procedures.

Solutions: Three sets of solutions would help to begin addressing these disparities:

- (1) **Price Transparency:** The U.S.'s market-based health care system has been stymied. Increasing price transparency through existing approaches like All-Payer Claims Data bases and through innovative insurance design would help to put downward pressure on price growth.
- (2) **Antitrust:** Hospitals account for nearly one-third of health care spending in the U.S. and are one of the most consolidated industries. Here, efforts to increase the number of mergers that the FTC challenges would be helpful. This would require increased funding and a new mandate to challenge consummated mergers.
- (3) **Administrative Simplification:** To help simplify administrative burdens, the goal should be to (a) streamline billing and claims processing as much as possible, (b) Address physician, and other care providers' time spent on billing and (c) Explore other approaches to identify ways to lower the administrative burden in the U.S.

The CHAIRMAN. Thank you, Dr. Jha.
Mr. Brennan, welcome.

STATEMENT OF NIALL BRENNAN, M.P.P., PRESIDENT AND EXECUTIVE DIRECTOR, HEALTH CARE COST INSTITUTE, WASHINGTON, DC.

Mr. BRENNAN. Thank you, Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee.

It is an honor and a privilege to have been invited to offer my thoughts and understanding on the cost of health care in America.

My name is Niall Brennan. I am President of the Health Care Cost Institute. HCCI is an independent, nonprofit organization founded in 2011 to foster greater understanding of health care spending trends, and the drivers of health care cost growth among

Americans with employer sponsored coverage, upon which almost one out of every two Americans rely.

Our data represents the roughly 40 million people each year covered by UnitedHealth Group, Aetna, Humana, and Kaiser Permanente. In addition to conducting our own research using this data, we also provide it to leading researchers and research organizations to conduct their own analyses. We use the data to build price transparency tools for consumers and states.

On the basis of our analysis of this data, I would like to make the following key points regarding spending trends in the ESI population.

First, after several years of relatively slow growth following the recession, per capita spending growth for health care for consumers with ESI is rising.

Second, the main driver of these increases in ESI spending, there has not been growth in the number of services used, but rather, growth in the cost per unit of service; a measure of which combines both increases in prices and shifts toward the use of higher priced services.

Finally, although there are differences in growth rates across types of health care services, those rates are increasing largely in tandem, suggesting that systemic factors are at work and that focusing on just one component of health care spending will have a limited impact on total spending.

Using the most recent HCCI data, we found the total spending per person in ESI plans averaged just over \$5,400 in 2016. This was a new high for this population. This number includes payments by insurers and consumers for health care goods and services, but does not include the cost of premiums.

We found that after several years of slowing spending growth, rates of growth are again increasing. After increasing by 4.1 percent between 2014 and 2015, per person spending increased by 4.6 percent between 2015 and 2016. These were the highest rates of growth we have seen in this population since 2009, when spending rose by 6.4 percent. In contrast, between 2009 and 2014, spending increases averaged a little over 3 percent a year.

Why is spending rising? We found that working Americans are using the same, or lower, quantities of health care, but are paying more for it every year. Utilization rates declined between 2012 and 2016 for hospital inpatient, outpatient, and professional services while increasing a modest 1.8 percent for prescription drugs.

For example, despite an almost 13 percent reduction in hospital admissions per 1,000 people, hospital spending actually rose by 8 percent between 2012 and 2016. Meaning that price increases and service intensity drove increases in hospital spending at a time when utilization had declined significantly.

We also found significant increases in prescription drug spending with all drug spending increasing by 27 percent between 2012 and 2015, and brand prescription drug spending increasing by 11 percent, while fill days decreased by 38 percent. This can only partly be explained by the introduction of new, high cost drugs like Sovaldi.

As for solutions, health care spending has proven highly resistant to most efforts to curb excess growth rates over a long period

of time. In part, because every dollar of health care savings represents lost revenue for an existing health system stakeholder.

I think by now we realize that there are no magic bullets, but there are important steps that we can take.

We need to better understand if factors, such as consolidation, are driving higher private sector health care prices.

We need to prohibit predatory practices such as out of network billing, which saddle unsuspecting consumers with crippling financial bills.

We need to educate both consumers and providers to work together to make more informed decisions that better take the cost of care into account.

This concludes my oral testimony.

Thank you very much.

[The prepared statement of Mr. Brennan follows:]

PREPARED STATEMENT OF NIALL BRENNAN

Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee, it is an honor and a privilege to have been invited to offer my thoughts on understanding the cost of health care in America. My name is Niall Brennan. I am the President and CEO of the Health Care Cost Institute (HCCI). HCCI is an independent, nonpartisan, not-for-profit organization founded in 2011 to foster greater understanding of health care spending trends and the drivers of health care cost growth among Americans with employer-sponsored insurance (ESI)—who account for nearly half of the national population in the United States. HCCI's data covers about one-fourth of all ESI enrollees under age 65, or roughly 40 million people each year over a 10-year period. In addition to conducting our own research using this data we also provide it to leading researchers and research organizations to conduct their own analyses, and use the data to build price transparency tools for consumers.

On the basis of HCCI's analysis of those data, I would like to make the following key points regarding spending trends in the ESI population:

- After several years of relatively slow growth following the recession, per person spending growth on health care services under ESI plans has been rising again toward pre-recession rates—both tracking with and contributing to the unsustainable health care spending trend for the country.
- The main driver of these increases in ESI spending has not been growth in the number of services used but rather growth in the cost per unit of service—a measure which combines increases in the prices of specific services and shifts toward the use of higher-priced services.
- Although spending growth rates differ across types of health services, those rates are increasing largely in tandem—suggesting that systemic factors are at work and that a combination of solutions will be needed to address the factors driving cost growth with all stakeholders contributing.

In the remainder of my testimony, I will provide an overview of recent health care spending trends in the ESI population, examine specific spending trends by type of service and discuss changes in consumer out-of-pocket spending.

Background on HCCI and its Data and Analyses?

HCCI possesses detailed claims data from four leading US health care organizations: United Health Group, Aetna, Humana, and Kaiser Permanente. HCCI receives data from these four organizations, and after a rigorous deidentification process to ensure patient privacy, we engage in a number of activities.

First, HCCI's in-house team of researchers and data scientists produce their own research and analyses on a range of issues. Our flagship publication is our annual Health Care Cost and Utilization Report which provides year-on-year and cumulative trends in health care spending for the ESI population—and this work will

form the basis for much of my remarks.¹ Beyond this report, however, we engage in a range of research examining issues such as geographic variation in health spending, the impact of high-deductible health plans on health spending, shoppable versus not shoppable health care services, and spending for populations with specific chronic conditions such as diabetes, hypertension and multiple sclerosis.

Second, we license our data to researchers to enable even more insights into the drivers of US health care spending. Researchers access HCCI data remotely via a secure data enclave. We're proud that the finest researchers and health policy analysts have chosen to use our data including the Congressional Budget Office, the Medicare Payment Advisory Commission, the CMS Office of the Actuary, the Federal Trade Commission, the Society of Actuaries, the American Academy of Actuaries and academics from a host of universities including Harvard, MIT, the University of Michigan, Dartmouth, Stanford, and others.

Third, we leverage our data assets to provide health care price transparency tools to consumers at the national, State, and local levels. In 2015, HCCI launched Guroo.com, an easy-to-navigate, consumer-friendly website that aggregated billions of claims from our partners at United Health Group, Aetna, and Humana into “care bundles” that allowed consumers shopping for care to understand the average costs associated with common services such as knee replacement and childbirth.² Recently, HCCI was selected through a competitive procurement by the State of Florida to help launch a facility-level, consumer-facing website to provide health care price transparency to all Floridians. This site, known as the FloridaHealthPriceFinder will launch in the near future.³

Finally, HCCI was the first organization—and remains one of a select group—to have been designated by CMS as a National Qualified Entity. Under this designation, HCCI receives 100 percent of Medicare fee-for-service data that it combines with its commercial data assets to advance public reporting on the quality and cost of care in the United States.

HCCI is governed by an independent board comprised of leading academics and health care experts.

Health Care Spending in the ESI population

Concerns about health care spending are not new, interventions are many and varied—and yet the one constant seems to be that spending on health care goes up every year, often significantly faster than inflation. According to the National Health Expenditures (NHE) estimates, the country spent a grand total of \$3.3 trillion dollars on health care in 2016, or about 18 percent of gross domestic product—that is twice the share in 1980.⁴ Focusing just on payments for health care goods and services (including hospital admissions, physician visits, prescription drugs, and nursing home care, etc.), spending nationwide totaled about \$2.8 trillion or approximately \$8,800 per person that year.

Health care spending growth challenges the budgets of governments, businesses, and families. The rapid growth in health care spending leaves less room for other investments, and this pressure will only increase over time if these expenditures continue to grow as projected.

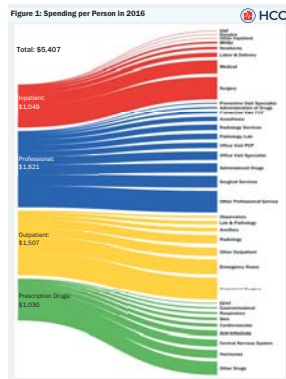
At HCCI, our analysis focused primarily on the ESI population, including workers, spouses, and dependents, which is somewhat younger and healthier than the US population overall. Using the most recent HCCI data, we found that total spending per person in ESI plans averaged \$5,407 in 2016—which was a new high for this population (see Figure 1). That amount captures payments by payers (employers and insurers) for health care goods and services and out-of-pocket costs paid by enrollees through deductibles, coinsurance, and co-payments; it does not include insurance premiums or insurers' administrative costs.

¹ Health Care Cost Institute. “2016 Health Care Cost and Utilization Report.” HealthCostInstitute.org, published January 23, 2018. <http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report>.

² Health Care Constitute. Guroo.com, accessed June 21, 2018. <https://www.guroo.com>.

³ Agency for Health Care Administration. FloridaHealthPriceFinder.gov, accessed June 21, 2018. <https://pricing.floridahealthfinder.gov>.

⁴ Centers for Medicare and Medicaid Services. “NHE Fact Sheet.” CMS.gov, last modified April 27, 2018. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>



In our analysis, we divided that spending into four broad categories:

- Inpatient spending, which consists primarily of spending on hospital admissions but includes some spending on skilled nursing facilities and other inpatient care, averaged \$1,049 per enrollee (19 percent of total spending).
- Spending on professional services—including physician visits, vaccines, physician-administered drugs, imaging services, and lab tests—averaged \$1,821 per enrollee (34 percent).
- Spending on services provided by outpatient facilities, including emergency room (ER) visits and outpatient surgery, averaged \$1,507 per enrollee (28 percent).
- Spending on prescription drugs—brand and generic—averaged \$1,030 (19 percent).⁵

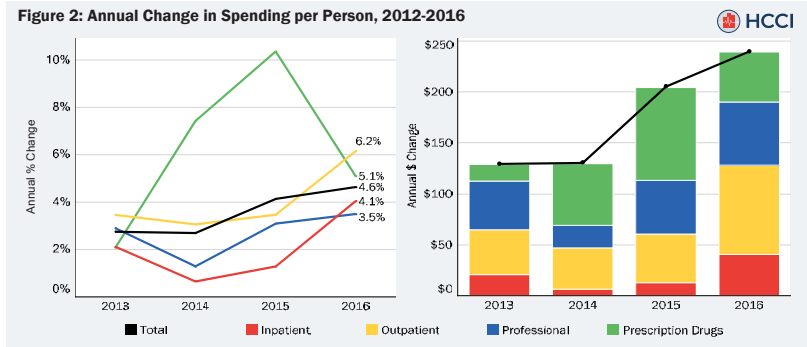
ESI Spending Trends, 2012–2016

Next, we turned to the question of how health care spending is changing. Examining trends in spending growth, we found that after several years of slowing spending growth, rates of growth are again increasing. Our analysis of more than 40 million people with ESI coverage found that per capita spending increased by 4.6 percent between 2015 and 2016 and 4.1 percent between 2014 and 2015—these were the highest rates of growth since 2009 when spending per capita rose by 6.4 percent. By contrast, spending growth per capita from 2009 to 2014 averaged 3.3 percent per year.⁶

Between 2012 and 2016, total health care spending increased 15 percent. In 2016, the annual health care bill for working Americans and their families in our sample was more than \$700 higher than 2012, not counting the cost of increased premiums.

⁵ Health Care Cost Institute. “2016 Health Care Cost and Utilization Report.”

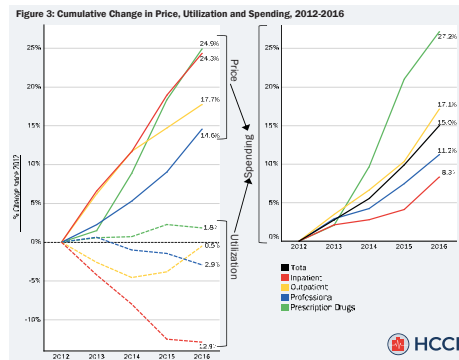
⁶ Herrera, Carolina-Nicole, Martin Gaynor, David Newman, Robert J. Town, and Stephen T. Parente. “Trends underlying employer-sponsored health insurance growth for Americans younger than age sixty-five.” *Health Affairs* 32, no. 10 (2013): 1715–1722.



Utilization is Not Driving Spending Growth

Why is spending rising? We found that working Americans are using the same or lower quantities of health care but are paying more for it every year. Based on our data, utilization rates—that is, in the number of services used—declined between 2012 and 2016 for hospital inpatient, outpatient, and professional services, while increasing a modest 1.8 percent for prescription drugs (see Figure 3). Despite a cumulative 12.9 percent reduction in hospital admissions per 1,000 people, hospital spending rose by 8.3 percent—meaning that price increases and service intensity played an important role in increasing hospital spending during a period of declining hospital utilization. Therefore, we conclude that spending increases are largely due to increases in the spending-per-unit of health care (which, for simplicity, we refer to as “price” per unit).

Figure 3: Cumulative Change in Price, Utilization and Spending, 2012–2016



We acknowledge that differences in service mix, quality, and the introduction of new technologies and therapies—which are often very expensive but only sometimes represent significant clinical advances—play a role in driving overall health care spending and distort the overall price effect we calculate. That being said, this should not distract us from the larger issue at hand—that health care spending continues to rise at a rate that will ultimately be unsustainable for the US economy.

Moreover, we are able in the HCCI data to account for growth in the intensity of care within service categories (using measures developed in Medicare such as relative value units for physician services and Diagnosis Related Group weightings for inpatient admissions). When we do that we find, for example, that while the average price of an inpatient admission rose by 24.3 percent between 2012 and 2016, the average intensity-adjusted price rose by 16.7 percent. Although overall trends in spending are also affected by shifts in the mix of services used across categories (for example, from care moving from inpatient to outpatient settings) we believe our

findings point strongly to the important role of price growth in spending trends for the ESI population.

Growth in Spending by Type of Service

A great advantage of the HCCI dataset is that we can use it to examine spending trends within service categories and subcategories to gain additional insights. In our most recent annual report, our analysis yielded the following findings.⁷

Inpatient Admissions. Inpatient utilization declined steadily from 2012 to 2016, continuing a long-established trend of declining inpatient utilization. The cumulative decline in inpatient utilization from 2012 to 2016 was 12.9 percent, while spending increased by 8.3 percent—meaning that the price of the average inpatient admission increased by 24.3 percent over this period. Surgical admissions were the largest contributor to the spending and price trends within the inpatient category. The price of a surgical admission, measured as the average facility fee for the average surgical admission, increased by nearly \$10,000 from 2012 to 2016 (from \$32,088 to \$41,702) leading to a 9.2 percent increase in spending despite a 16.0 percent decrease in utilization.

Outpatient Services. The use of outpatient services declined from 2012 to 2014 but increased between 2014 and 2016, resulting in a small net decline in outpatient utilization between 2012 and 2016. However, outpatient spending rose every year, with a cumulative increase of 17.7 percent—which appears to be largely attributable to increases in price per unit. For example, ER visits comprised 23.4 percent of outpatient spending and saw a cumulative price increase of 31.5 percent from 2012 to 2016.

Professional Services. Declines in the use of professional services represent a comparatively recent trend, as use of these services decreased every year since 2013. Despite declines in use, spending on professional services increased a cumulative 11.2 percent from 2012 to 2016, while the average price per service increased a cumulative 14.6 percent. The professional service subcategory with the greatest increase in average price per service was administered drugs. The average price of administered drugs increased dramatically since 2012, a cumulative 41.9 percent to an average of \$581 per service in 2016.

Prescription Drugs. Although the utilization of prescription drugs remained relatively constant over the study period, spending on all prescription drugs grew a cumulative 27.2 percent. A large component of this growth was increased spending on brand name prescription drugs. While annual spending growth on generic drugs has been driven largely by increased use, increased spending on brand prescription drugs was due to increases in average price per filled day (a standardized measure of prescription prices).

The average price—measured through allowed amounts, not including any coupons, discounts, or rebates—for a filled day of a brand prescription drug increased more than 20 percent per year from 2012 to 2015, and grew 15.0 percent from 2015 to 2016, for a cumulative growth of 111 percent from 2012 to 2016. Part of the substantial price growth of brand prescription drugs is in part explained by the introduction of new drugs that feature both high prices and breakthrough clinical improvements and outcomes (e.g., hepatitis C antivirals that first became available in 2013) and the decline in use of lower cost brand drugs after patent expirations (e.g., Singulair and Lexapro in 2012, Nexium in 2014).^{8,9} However, the change in the mix of prescription drugs due to innovative new therapies and patent expirations does not fully explain why spending on brand prescriptions continues to increase each year as use continues to fall.

Spending Variation Across States

HCCI's dataset covers enrollees in every State so we are able to examine differences in spending per capita across states (with adjustments to make the data representative of the national under-65 population with ESI). Alaska and Hawaii have unique issues regarding health care and can be difficult to compare to other states, but even within the continental U.S. average spending per capita varied widely around the national average of \$5,407 in 2016 (see Figure 4). Eight of those

⁷ Health Care Cost Institute. "2016 Health Care Cost and Utilization Report."

⁸ Chhatwal, Jagpreet, Fasiha Kanwal, Mark S. Roberts, and Michael A. Dunn. "Cost-effectiveness and budget impact of hepatitis C virus treatment with sofosbuvir and ledipasvir in the United States." *Annals of internal medicine* 162, no. 6 (2015): 397–406.

⁹ Deruiter, Jack, and Pamela Holston. "Drug Patent Expirations and the 'Patent Cliff.'" U.S. Pharmacist, published June 20, 2012. <http://stage.uspharmacist.com/article/drug-patent-expirations-and-the-patent-cliff>.

48 states had average spending of over \$6,000 per capita led by Wyoming at \$6,916, while nine states had average spending below \$5,000 per enrollee, with Utah the lowest at \$4,415.

Geographic differences in spending for working individuals can stem from a number of factors from differences in the cost of services across locations, to differences in the age, health and socioeconomic influences of enrollees, to differences in how providers treat patients. One recent study showed that in the ESI population about half of the variation in spending may be due to differences in prices across locations.¹⁰ However, there is an ongoing debate among healthcare researchers on this issue, with some drawing important inferences from spending differences in Medicare and others raising questions about those findings and their implications.^{11,12} Further analysis about the geographic differences in spending among the ESI could yield important insights.

Effects on Consumers and Budgets

HCCI also focuses on the effect that these trends are having on consumers through out-of-pocket (OOP) payments. Over time, people with ESI are generally using fewer inpatient, outpatient, and professional services, but the amount of OOP payment continues to increase. OOP spending, while displaying a slightly lower overall cumulative growth rate than total spending between 2012 and 2016 (12 percent versus 15 percent). However, for most services OOP spending is actually rising faster than total spending, the exception being prescription drug spending where average OOP declined significantly, although this decline was primarily driven by steep declines in OOP spending for a small number of people with very high prescription drug spending.

More importantly, the cost of insurance coverage in the form of premiums is a significant and growing burden for working individuals and families. For example, the Kaiser Family Foundation and Health Research and Educational Trust (HRET)'s annual survey of employers found that the average contribution of workers toward their premiums increased 22.3 percent between 2012 and 2016.¹³

Individual Spending is Often Unpredictable

In addition to the rising burden of OOP costs, it is important to remember that most health care spending is concentrated among a small group of people. Indeed, in a recent analysis we found that from 2009 to 2015, the top 5 percent of people—so called “top spenders”—accounted for over half of all health care spending, consistent with many previous studies.¹⁴ However, we also found that each year most top spenders—more than 60 percent—were different from the year before.¹⁵

In other words, high health care spending annually affects new people. In 2015, for example, the median new top spender faced an over \$3,000 increase in their OOP spending from the previous year. To put this spending increase in context, the Federal Reserve Board's 2017 Survey of Household Economics and Decision reported that 41 percent of respondents could not afford even a \$400 emergency expense.¹⁶

¹⁰ Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. *The price ain't right? Hospital prices and health spending on the privately insured*. No. w21815. National Bureau of Economic Research, 2015.

¹¹ Song, Yunjie, Jonathan Skinner, Julie Bynum, Jason Sutherland, John E. Wennberg, and Elliott S. Fisher. “Regional variations in diagnostic practices.” *New England Journal of Medicine* 363, no. 1 (2010): 45–53.

¹² Reschovsky, James D., Jack Hadley, and Patrick S. Romano. “Geographic variation in fee-for-service Medicare beneficiaries' medical costs is largely explained by disease burden.” *Medical Care Research and Review* 70.5 (2013): 542–563.

¹³ The Henry J. Kaiser Family Foundation. “2017 Employer Health Benefits Survey.” KFF.org, published September 19, 2017. www.kff.org/health-costs/report/2017-employer-health-benefits-survey.

¹⁴ Johnson, William, Niall Brennan, Sally Rodriguez, and John Hargraves. “Consistently High Turnover in the Group of Top Health Care Spenders. NEJM Catalyst, published February 1, 2018. <https://catalyst.nejm.org/high-turnover-top-health-care-spenders/>.

¹⁵ Johnson, William and Sally Rodriguez. “Top Spenders Among the Commercially Insured: Increased Spending Concentration and Consistent Turnover from 2013 to 2015.” HealthCostInstitute.org, published February 2018. <http://www.healthcostinstitute.org/wp-content/uploads/2018/04/Issue-Brief-Top-Spenders.pdf>.

¹⁶ Board of Governors of the Federal Reserve System. “Report on the Economic Well-Being of U.S. Households in 2017.” FederalReserve.gov, published May 2018. <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf>.

The jarring impact of unpredictable health care spending on individuals' will only become worse as the cost of health care continues to rise.

Conclusions

Individuals and families with ESI coverage represent nearly half of the U.S. population, and our report suggests that health care spending growth for this population is trending in the wrong direction. Despite the recent attention around value-based care approaches as a means to reducing health care costs and improving quality, the reality is that across the health care system as a whole, spending is projected to increase from 17.9 percent of GDP in 2016 to 19.7 percent in 2026.¹⁷ Put another way, U.S. health care spending in 2025 will be \$2.3 trillion dollars higher than it was in 2016.

Yes, there will be innovative new drugs and technologies, and yes, some of them may be expensive, but that alone does not explain the rapid price and spending growth in U.S. health care nor does it guarantee higher value care. We believe there needs to be a meaningful conversation among all stakeholders across the U.S. health care system to better understand the causes and drivers of increased health care spending. Bringing these groups together can lead to meaningful policy decisions that continue to respect and reward innovation in health care within the parameters of a sustainable health care system.

[SUMMARY STATEMENT OF NIALL BRENNAN]

Mr. Brennan is the President and CEO of the Health Care Cost Institute (HCCI) in Washington, DC. HCCI is an independent, nonpartisan, not-for-profit organization founded in 2011 to foster greater understanding of health care spending trends and the drivers of health care cost growth. After providing background on HCCI, Mr. Brennan's testimony reviews details of health care spending in the population of Americans with employer-sponsored insurance (ESI) coverage. Between 2015 and 2016, per enrollee spending for this population grew 4.6 percent, representing the highest rate of growth since 2009, and pushing average total spending per person in ESI plans to \$5,407—a new high for this group. In HCCI's analysis, utilization is not driving spending growth. Between 2012 and 2016 the number of services used declined for hospital inpatient, outpatient, and professional services, while increasing a modest amount for prescription drugs. HCCI concludes that spending increases are largely due to increases in the spending-per-unit of health care (which, for simplicity they refer to as "price" per unit). Mr. Brennan next turns to the effect of these spending trends on consumers and budgets. Average out-of-pocket (OOP) spending, including deductibles, copayments, and coinsurance are growing at roughly the same rate as plan payments. In addition, premiums for individual and family coverage have increased, with the employee's contribution rising 22.3 percent between 2012 and 2016. To conclude, Mr. Brennan points out that spending for the ESI population is increasing in tandem with spending across the health care system overall—national health expenditures are projected to increase from 17.9 percent of GDP in 2016 to 19.7 percent of GDP in 2026. This suggests that systematic factors are at work and a combination of solutions will be needed to address the factors driving cost growth with all stakeholders contributing.

The CHAIRMAN. Thank you, Mr. Brennan.
Dr. Hyman.

STATEMENT OF DAVID HYMAN, M.D., J.D., PROFESSOR, GEORGETOWN UNIVERSITY LAW CENTER, WASHINGTON, DC.

Dr. HYMAN. Thank you, Chairman Alexander and Ranking Member Murray, for inviting me to speak to you today.

Much of what I am going to say is drawn from a book that is coming out in about a week called, "Overcharged: Why Americans Pay Too Much for Health Care." I am happy to make copies of that available to Members of the Committee or their staff.

¹⁷ Centers for Medicare and Medicaid Services. "NHE Fact Sheet."

My written testimony and my remarks today address three questions, some of which have already been preempted by my distinguished fellow panelists.

First, how expensive is health care in the United States and who pays for it?

Second, why is American health care so expensive?

Third, what should we do if we want to make health care in the United States less expensive?

I think there is broad agreement, not just among health policy analysts, and not just the health policy analysts on the panel, and also among the general public, on the first question, that health care in America is quite expensive.

The figures for the GDP make sense to economists, but I think a better way of looking at it is the per capita figures that you heard earlier; roughly \$10,000 for every man, woman, and child in the United States. It is also useful to compare that to, say, the median household income of about \$60,000.

Now, households are obviously typically, on average, made up of more than just one person. So you can, say, multiply by two-and-a-half and then divide into 60. You get a very sizable share of Americans' income as being devoted to health care. And I think lots of people feel like that is too much and the value of care that they are receiving is not necessarily self-evident. Not much disagreement on that.

On the who pays question, it is quite common to say, "Well, the government pays 40-some percent and individuals through their employment-based coverage or otherwise are paying the balance."

The reality is, of course, the Government obtains the funds that it spends by taxing individual households and by issuing debt, which is a call on future taxpayers. So the reality is all Americans are paying this. There is no separate bucket of money that we can call the Government.

There is lots of concern, as you have heard earlier and heard from both the opening remarks by Chairman Alexander and Ranking Member Murray, about high bills, about surprise medical bills, about out of network bills.

I think the important point to recognize about all of this, that Professor Buntin alluded to earlier, is you should think separately about the high cost of health care and the rate of growth of health care because, although they are related, strategies to address one may not do much about the other, and vice versa.

On why is American health care so expensive, I am ashamed to speak about this with Dr. Jha on the panel because he has a recent article on the subject in "JAMA" that I commend to you, along with the four or five commentaries that do a nice job of comparing across ten wealthy countries other than the United States, the break down of spending into various buckets. They make clear that we are No. 1 in health care spending, not necessarily something that we should be bragging about.

Now, there are complications. The composition of that needs to be paid attention to and in terms of the causes, we have already heard discussion about monopoly in particular markets. Sometimes we create monopolies deliberately. That is what the patent system does for pharmaceuticals. And sometimes licensed professionals

have monopoly positions as well. But any competitive practices are, I think, a persistent problem.

Viewed from a broader perspective, our health care system is expensive because we set it up to be expensive. Every incentive points in the direction of higher spending. There are neither supply side nor demand side real constraints on what health care is provided, and more importantly, the price at which it changes hands.

Attempts to do that have given rise to cries of rationing followed by lobbying and lawsuits with the results that we see around us; the \$10,000 per capita, which is the result of a long run increase in spending every year running well ahead of general inflation.

What should we do about it? Well, everyone else on the panel seemed to have three ideas. I have 13 that I put down.

[Laughter.]

Dr. HYMAN. Five of them are about pharmaceuticals. In the 30 seconds that I have left, I am not going to try and go through them all.

I certainly agree that we should do more things on transparency and addressing market consolidation.

I think payment neutrality is something that you ought to be looking at that has not been mentioned. That is actually one of the drivers of consolidation. I think you should explore competitive bidding for Medicare Advantage.

I see my time has expired, so I will stop there.

[The prepared statement of Dr. Hyman follows:]

PREPARED STATEMENT OF PROFESSOR DAVID A. HYMAN

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 second question—and vehement disagreement on the answer to the third 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 percent 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

¹ For my own recent contribution to the pile, see Charles Silver and 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-poverty.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 percent of GDP on

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 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 percent of the population (in terms of health care spending) accounts for 51 percent of total health care spending, and the top 20 percent accounts for 83 percent of health care spending.¹⁰ Conversely, the bottom 50 percent of the population (again in terms of health care spending) accounts for only about 3 percent 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 percent 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 slowdown (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 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 me-

health care in 2016. The next biggest spenders were Switzerland (12.4 percent), Germany (11.3 percent), and Sweden and France (11.0 percent).

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/>.

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.

dian. 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 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

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>.

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.

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.
- 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 plus 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.

[SUMMARY STATEMENT OF PROFESSOR DAVID A. HYMAN]

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? My testimony provides responses to each of these questions, and highlights areas of agreement and disagreement.

First, a solid body of research makes it clear that high prices are a major factor in why American health spending is so high. For example, a study published in 2018 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.” To be sure, there are various complications, including a variety of volume/composition differentials that must also be taken into account. And, there is tremendous waste, fraud, and abuse in our health care system.

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.

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. My forthcoming book, *Overcharged: Why Americans Pay Too Much For Health Care*, 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 market entry.
- Move as many drugs as possible from Medicare Part B to Medicare Part D.
- 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 plus a modest percentage.

The CHAIRMAN. Well, thank you, Dr. Hyman.

Thanks to the four of you. That is a terrific introduction to our discussion, I think we would all agree, and we are all looking forward to a 5 minute round of questions.

If I may say at the beginning, our goal is to try to move the discussion for four or five hearings from this. Rather than perpetuate the stalemate we have had over health insurance or specifically 6 percent of the health insurance market to a larger discussion of reducing the growth of health care costs.

Senator Murray and I work very well together and we have solved many problems. We have not won any prizes on health insurance and we have very distinct views about why we have not. I am not going to revisit that, although I am able to.

What I would like to say that while Senators are able to say whatever they would like in their time, I hope we can focus on the larger picture, particularly with such distinguished witnesses today.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

I really appreciate this panel and the suggestions that they have given. I am going to take it, though, to a lower level. I am from Wyoming, which is the least populated state in the Nation. So I am really interested in ways that we could encourage or support competition, or do any of the other things that you mentioned.

I loved your example of the \$10 pizza. If there is nowhere else to go, you buy the \$10 pizza. That is one of the problems we have in a small population state. Our biggest city is 60,000 people. Our towns are all 40 miles apart. There are only 19 towns where the population exceeds the elevation.

[Laughter.]

Senator ENZI. We face some of the highest health care costs in the country.

There are no competitive hospitals in any of the communities, and we lack a lot of specialists. So they go out of state for their specialist which, I guess, would be out of network.

I am open to any suggestions that you might have for ways we can bring that down. I will be doing a subcommittee hearing on rural and frontier health care costs as well.

Does anybody want to kick that off?

Dr. Hyman.

Dr. HYMAN. Obviously, your difficulty is not unique to Wyoming. Many states have significant rural areas where the population density is not very high and the population that is necessary to sustain a good hospital can make it very difficult to have in significant parts of the country. So, I do not think there is a magic solution to that.

I think if you want to broaden access, one strategy to consider is your state policy on telemedicine, which makes it possible for people to treat patients remotely, including across state lines. Now, this is an issue of state law, rather than Federal law historically.

The other thing that is worth considering is your state policy on the use of physician assistants and nurse practitioners because physicians are expensive to train and they are expensive people to have around. You can use these other paraprofessional strategies to broaden access. Not a perfect solution by any means.

Senator ENZI. Does anyone else care to comment?

Dr. BUNTIN. If I might add to that.

Yes, this problem is not unique, so it is such an excellent question to bring up at this point in the hearing. Tennessee, obviously, has a number of very rural areas as well.

There are a couple of ways to think about setting up beneficial competition, and that is what some of the demonstrations being run by states, and the Federal Government, and in many cases—in fact, sometimes more often now—by private insurers.

That is to set targets or benchmarks so that hospitals, or groups of providers, can compete against themselves and then share savings with insurers or with governments, if they achieve them.

Another way to think about it is to set up competition across areas, beneficial competition about whether you can achieve the same health outcomes at lower cost.

I agree. It is a really large challenge for rural areas, and we probably cannot use the same methods of competition as we can in urban areas, but we can get creative about the types of competition we introduce into the system.

Senator ENZI. Thank you.

Since we are running out of time, if the other two have suggestions on that, if you could provide them in writing, I would appreciate it because I want to ask Dr. Hyman another question based on one of his 13 issues.

Senator ENZI. Providers are sometimes forced to toss expired biomedical products that have been purchased, but not used. That is a waste of money and can be particularly concerning during a shortage situation.

Products do not necessarily expire exactly on the expiration date. We know this because the Food and Drug Administration sometimes extends those dates. Of course, it might not always be appropriate for a manufacturer to pursue an extension. We should not assume that every product that is thrown out is one that was safe for human use, especially when the products might be stored in a variety of conditions.

I was surprised when Wyoming hospitals told me their saline for fluid bags expired after just 1 year. I did not know that salt and water had an expiration.

I would be interested in how we can accurately reflect product shelf life to prevent waste and how that might affect health care costs.

Dr. HYMAN. That is a very interesting question, Senator. I do not hold myself out as an expert on FDA expiration policies, but they strike me as the people to go and talk to about overly aggressive shelf life expiration dates.

My wife throws out jam the instant that the date runs, even though I explain to her as long as it is refrigerated. She is not interested. It does not matter how many degrees that I have. Now, I am not suggesting jam is equivalent to hip implants or things like that.

[Laughter.]

Dr. HYMAN. It is probably closer to saline, however.

Senator ENZI. Yes.

Dr. HYMAN. This is a subset of a broader problem of waste in the American health care system.

My written testimony alludes to the fact that the standard estimate is between fraud, waste, and abuse respectable researchers think that number is north of 25 percent and perhaps 35 percent.

Your example is a subset of a much broader problem that we are facing. Sometimes it is beneficial financially for institutions to throw away things because they can bill more and get paid more for doing so.

Senator ENZI. Thank you.

My time has expired. I have other questions that I will submit in writing. If you would be so kind, you are such a wealth of information, all of you. I appreciate it.

The CHAIRMAN. Thank you, Senator Enzi.

Senator Murray.

Senator MURRAY. Thank you to all of our witnesses for really great testimony. I appreciate it.

Dr. Buntin, you talked about the importance of continuing to change the way we pay for health care. You noted that investing in models that pay for the right care, instead of just paying for more care, quote, "Sends a strong signal to the health care industry."

My state is sending that signal. The Washington State Health Care Authority set an objective that all of its programs, including Medicaid and benefits for state employees, will shift 90 percent of payments to systems that reward quality and efficiency by 2021.

The Obama administration had set a similar objective, by the way, that 50 percent of Medicare payments be alternative payment

models rather than traditional volume-based payments by 2018. Those type of payment changes matter.

Efforts by CMS, and the Agency for Health Research and Quality, to reduce hospital acquired conditions may have prevented an estimated 8,000 deaths between 2014 and 2016. So I was disappointed that the Trump Administration backed away from that commitment earlier this year.

Dr. Buntin, can you talk to us about why those signals matter to the health care system? How can we continue to help these providers invest in models of care that keep our patients healthy in the first place?

Dr. BUNTIN. Yes. Thank you so much, Senator Murray, for that question. I think this is an important point that has not received enough attention.

Every day, medical practices in states like yours are making decisions about what to invest in. I can tell you that setting targets, like the targets set by the Washington State Health Care Authority, targets set by states like Massachusetts, and like the other ones that you mentioned, change the conversation in “the C-suite” about what investments should be made.

Whether that investment is to upgrade an Electronic Health Record so that you can better manage the care of diabetics, or buy a new MRI machine when there are five other ones in town, that emphasis on value really does matter.

As I said during my testimony, convincing providers that we are going to, if you will, keep the pressure on toward value-based payment really makes a big difference.

If we continue in all areas to both partner with public and private insurers to emphasize value-based demonstrations—like the ones going on in Washington State where there are accountable care organizations, shared savings programs, or numerous providers have adopted bundled payment strategies—if we organize them so that those incentives are aligned and providers know that they are participating in that same program.

For example, for state employees, and for privately insured people, and for their Medicaid patients, then they will be self-reinforcing. I think that will change the trajectory of our health care costs meaningfully over time.

Senator MURRAY. Thank you.

Mr. Brennan, we often hear health care is one of the only industries where patients do not know the price of a service before they purchase it.

In a recent article, I saw you say that is partly because of our complex health care system. And you actually said, “We do not expect the average consumer to buy the individual components that comprise a car,” which raises a really important point.

For transparent price information to be actually useful, patients need to know how much of their cost the insurance covers. They need to know which providers will give them care. And they need to know whether those providers are actually in the network. So it is very complex.

I wanted to ask you, what information do you think patients need to have price transparency?

Mr. BRENNAN. Thank you, Senator Murray.

It is a great question and price transparency is a great idea. I have been an advocate of greater transparency in health care for many years dating back to my time at CMS. I think the question is there is just a fundamental lack of standards in the field now.

Actually, I was prompted by Senator Alexander's comment on Electronic Health Records. I think the failure of Electronic Health Records was a failure to put the provider at the center from a user-centered design perspective. I really hope that as we make progress with price transparency initiatives, we place the consumer at the center. We put ourselves in their shoes.

Is a price a charge? Is a price a negotiated rate? Is a price your out-of-pocket payment on a negotiated rate? Is a price a single service? Or is a price a bundle of services that represent a hip replacement or a knee replacement?

These are all really important things and if we do not approach it in a very careful manner, I think we may miss a real opportunity to engage consumers with tools that can help them.

Senator MURRAY. That they actually understand it.

Mr. BRENNAN. Yes.

Senator MURRAY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman, for holding these important hearings.

Dr. Jha, you talked about the importance of price transparency and that is something that is of great interest to me.

In the State of Maine, for example, the cost of a knee replacement can vary from less than \$25,000 to more than \$50,000. The state recently has passed a law that says if the consumer can find a lower cost than would be covered by his or her insurance, that the savings are split between the insurer and the patient which, I think, is very innovative.

But researchers have also found that patients equate high prices with high quality. It reminds me of when people shop for colleges, they assume higher cost colleges are better colleges, which is not necessarily the truth.

We are not dealing with a normal market here. It seems to me that when we have price transparency, we need to have some way to also have an evaluation of quality.

Do you have any thoughts on that?

Dr. JHA. Senator Collins, you have made an incredibly important point that I often make, which is in talks on this topic, I start off, I ask people, "If you had a choice between a \$1,000 laptop and a \$2,000 laptop, and your co-pay was \$100, which one would you pick?" Everybody wants the \$2,000 laptop because the assumption is, it is better.

The only way price transparency works is, as you said, if you have quality information, and that is how we do tradeoffs.

Sometimes we say, "You know what? I do not want to pay for the \$2,000 laptop because the marginal benefit is not worth it for me." Right now, we have tools that cannot even help you figure out whether it is a \$1,000 or a \$2,000.

I think what the State of Maine is doing is progress in that. There have been other areas where we have seen this. Reference pricing is another effort that California tried where there was a reference price for a knee replacement. And then, if you wanted to get a knee replacement somewhere else, you had to pay the difference. That is another pretty good mechanism that keeps prices down.

But none of it works without quality information because at the end of the day, if you are helping your mom figure out where to get her knee replacement, you do care about prices. But you care incredible amounts about quality and what we know is that quality varies tremendously between providers.

Even though I brought up price transparency as one of the things that I would push for, I am incredibly grateful for you bringing up the point that, onto itself, is not going to work.

Actually, without quality information, there is reason to believe it is going to make things worse because people are going to use price as a measure or a marker of quality and go down that road. So we really do have to address it.

Senator COLLINS. That is exactly what I think. Thank you for your laptop example because that is a perfect one.

Mr. Brennan, since you are familiar with CMS reimbursements. A lot of the reimbursement policies from CMS do not promote early intervention. I want to give you two examples.

One is colorectal cancer screening. If you have a colonoscopy, and it is called "a screening test," CMS pays for that, Medicare pays for that for seniors. But if the physician removes a polyp while you are under anesthesia, then the cost shifts to the patient.

I have had specialists in Maine tell me that when patients realize that, they cancel the screening. It just does not make sense to me.

Another example has to do with diabetes care. There is a practice in Maine that does a great job of once a week, calling people with Type 2 diabetes, checking on their compliance with diet, with exercise, and what their blood sugar readings are. They do not get reimbursed for that call.

Yet, if that person with diabetes loses a limb, or goes blind, or has a stroke, we will pay for all of those costs.

What could we do in the reimbursement area?

Mr. BRENNAN. Thank you, Senator Collins. That is a great question.

I think most people on the panel would agree that we do a really good job of treating sickness in America, but we do not necessarily do a good job of managing and treating health.

I obviously no longer speak for CMS, but I would draw your attention to a lot of the innovative programs at the Center for Medicare and Medicaid Innovation, particularly their efforts around better treatment and management for patients with diabetes that encourage precisely the type of behavior that you want to see from a reimbursement perspective.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Casey.

Senator CASEY. Thanks very much, Mr. Chairman.

I want to thank the panel for being here.

I know that in the testimony of Dr. Buntin, I wanted to go to Page 9 of your testimony. In the middle of that page, you said the following, "On the consumer demand side, I am less optimistic about opportunities to contain cost growth without doing harm. While work I conducted with colleagues at RAND suggests that high deductible health plans can reduce health care spending, the effects are attenuated by accounts like HSA's. We also found evidence that consumers cut back on investments in preventive care when faced with high deductibles, even when preventive care is exempt from deductibles and cost-sharing."

That is the predicate for the question.

As you know, there has been a huge debate here about Medicaid and where to go with Medicaid, and frankly, more than animated debate, a lot of intensity behind the debate. I have been part of that and I will continue to be.

Could you discuss the impact such changes as you refer to in this paragraph could have on Medicaid beneficiaries given the limited resources that these beneficiaries usually have available?

Dr. BUNTIN. Yes, thank you for the question.

I think that this is an important point and there has been research, since the research that I conducted, that has confirmed many of these findings.

There are savings that can be achieved by putting people into high deductible plans, but they tend to be rather across the board savings. People cut back on both necessary and unnecessary care when faced with high deductibles.

There was hope that by exempting certain services, like preventive services from those high deductibles, and by putting moneys into Health Savings Accounts and other vehicles, that might help people to make better choices.

Evidence seems to indicate, so far, that these policies are confusing and that people do still continue to cutback on their preventive care.

Turning to what you asked about Medicaid, what does this mean? For a low resource population, I would have really great concerns, especially since most of the research done to date has been on employee populations that probably have better financial resources and better access to information.

We do have some states, like the State of Indiana, that are conducting experiments about the use of Health Savings Accounts for Medicaid beneficiaries.

I think they really should be seen as experiments and we should know the full results of those state level experiments before we expand them further.

Senator CASEY. Well, I appreciate that. And any follow-up research you think we should review, I hope you will send that our way.

Dr. BUNTIN. I would be happy to provide that to the Committee.

Senator CASEY. Thanks very much.

In the remaining time that I have, I know that we have had a lot of discussions, not only in this Committee, but more broadly about lack of broadband access or, I should say, lack of access to high speed Internet and broadband in rural areas.

I know that Senator Enzi asked a question related to this earlier. I was not here when he asked, but my staff informed me of that.

I live in a state that has 67 counties and 48 are rural. We have one of the largest rural populations of any state in the country just because we are a big population state and have a disproportionately high number of people living in those areas, literally millions of Pennsylvanians.

In those areas, you can go into counties where it is 40, 50, even 60 percent of the people living in the county do not have access to high speed Internet. It is bad for children in school. It is bad for small businesses. It is also bad for health care.

We had an article that just appeared in the "Pittsburgh Post-Gazette," dated the 26 of June. I will read the title and just ask that it be submitted to the record. The title is, "Lifeline Offline: Unreliable Internet, Cell Service Are Hurting Rural Pennsylvania's Health."

Mr. Chairman, I would ask consent to have this article be submitted as part of the hearing record.

The CHAIRMAN. Be so ordered.

Senator CASEY. Thank you.

Dr. Hyman, we will submit for you some questions for the record that relate to this, but obviously when you have that many people within one state that do not have access to high speed Internet, you are going to have health care issues with it.

We are grateful if you would look out for those questions for the record and answer them.

Thank you.

The CHAIRMAN. Thank you, Senator Casey.

Senator Cassidy.

Senator CASSIDY. Mr. Chairman, thank you for holding this.

Will there be a second round? Just curious.

The CHAIRMAN. Sure, if you want to stay and ask a second round of questions, I will stay with you.

Senator CASSIDY. Okay. That sounds great.

Thank you. Loved your testimony.

On my Website, Cassidy.Senate.Gov, I will be as shameless as you, Dr. Hyman. I have an eight page whitepaper. I would love your input, and a lot of it is reflected in what you say, but we are trying to stimulate conversation.

[Chart.]

Senator CASSIDY. Thank you.

I am going to ask some questions that I, frankly, do not know the answer to, which is sometimes not what I do.

Dr. Buntin, you mentioned, and I think Dr. Jha, you mentioned that Medicare spending has been flat. We speak of the prices associated with that.

You see here, though, that the employer sponsored insurance, and I will show this to my colleagues, in employer sponsored insurance, it has skyrocketed.

Why is it flat in Medicare and why is it skyrocketing here? Dr. Jha.

Dr. JHA. Well, I think Medicare, there is actually, Dr. Buntin actually laid out, I think, several reasons why we have seen a relatively flat cost growth in Medicare. Medicare costs have gone up

as more Americans have become older and entered the program, but per capita cost growth in Medicare has been slower.

Senator CASSIDY. Let me ask.

Dr. JHA. Yes.

Senator CASSIDY. Because Dr. Buntin, it was unclear from your testimony if you weighted that, because you mention per capita costs as falling because younger Baby Boomers are ending. It was unclear in your testimony if you weighted that; if you did a retrogression.

Dr. BUNTIN. Thank you. Thank you for the opportunity to clarify that.

Yes, even if you adjust for the fact that beneficiaries entering the program are younger, the costs are still relatively flat.

Senator CASSIDY. I am sorry. So continue, Dr. Jha.

Dr. JHA. No, it is great.

I think the important issue, and this is something Mr. Brennan brought up as well, is the utilization of health care services has been falling. People are spending less time in hospitals. That is a good thing.

Senator CASSIDY. Now, I have heard a theory that it is falling because it is more expensive, so they forego the expense. They forego the kind of discretionary lower cost care instead, but have to get the more expensive care.

Dr. JHA. Yes, so when I look at things like hospitalization, which is expensive, the decline on this has been very clear and in one direction. It started quite a while ago where the number of days Americans spend at the hospital has been declining for at least a good 10, 15 years. And again, I see that as a good thing. I see that as more people are healthy.

The big difference between Medicare and private insurance is Medicare, the prices are set. We can talk about whether the prices are too high or too low.

Senator CASSIDY. Let me ask you.

Dr. JHA. Yes.

Senator CASSIDY. We have a problem in the individual market.

Dr. JHA. Yes.

Senator CASSIDY. In which there is a concentration of insurers and we cannot get new folks to come in.

Dr. JHA. Yes.

Senator CASSIDY. Now, somebody pointed out to me, part of the competitiveness of Medigap is that the Medigap insurers know the price is set. And so, therefore, they do not have to put together a provider network and bargain. Rather, they can come in and take Medicare prices.

Dr. JHA. Yes.

Senator CASSIDY. Tennessee has a lot of counties without, as I recall, that are bare. No insurer. Iowa has a lot. Louisiana has some with only one.

If we said, "Wait a second." If you have a place like Tennessee, Iowa, part of Louisiana, which is bare, if we said a new insurer could pay a 1.1 or a 1.2 ratio of Medicare rates and go into business, as long as they have capital reserves, would that be part of the solution?

Dr. BUNTIN. I think a good example of that, and I am actually happy to say that Tennessee has seen a number of insurers entering this year. And so, we do think the market will look better next year, and I think that is an indication that market is stabilizing.

But to answer your question, if you look at what private insurers are saying, for example, to their investors, they are saying that getting into providing Medicare Advantage and Medicaid plans is where the good business is.

That is because explicitly by regulation in Medicare Advantage, they can key off of Medicare prices for out of network care.

Senator CASSIDY. Again, to the point, if our problem is that we cannot get folks into the individual market, if we said, "You can take advantage of Medicare rates, even a multiple," that would be something that could maybe invite more folks in. I am just putting that out as a thought experiment.

Dr. BUNTIN. I think it would give a lot of insurers the guarantee about getting into new markets that would make it more attractive to them. Yes.

Senator CASSIDY. Okay.

Dr. JHA. The only quick thing I will add is in a lot of markets where there is a tremendous amount of market power by providers, something like that, I think, creates both certainty and a certain price point.

Senator CASSIDY. Let me stop because you are with Partners. Partners led this consolidation in Boston. It has driven up costs 12 percent. I am admiring your intellectual honesty in criticizing your employer. I hope you have a job tomorrow. But let me ask.

I have been told that some of this consolidation takes place as Baby Boomers get off of Blue Cross, if you will, and into Medicare, margins fall and less efficient hospitals cannot stay afloat. Part of the consolidation is the inefficient are purchased by the efficient, and therefore the market consolidation is almost inevitable.

As opposed to Partners where, frankly, they came together when they were both making good margins independently.

Dr. JHA. For the record, Senator, I am employed by Harvard University and also the Department of Veterans Affairs, because I practice medicine—

Senator CASSIDY. Got you.

Dr. JHA. —taking care of veterans. So my friends the Partners are not going to be as happy about this, but I do think the consolidation problem is real.

Without commenting specifically on Partners, what I will say is on the issue that you raise of inefficient hospitals, I believe if you, again, look at the broad trends in American health care, and we are not talking about rural areas. We are not talking about Wyoming or parts of Pennsylvania, but we are talking about in cities like Boston and bigger cities, we probably could stand to have fewer hospitals.

When those hospitals get bought up by large systems, they stay in business and then the market power makes it actually, I think, a real challenge for increasing prices. So I think it is a complicated interplay.

There are certainly areas where you have critical hospitals that you need and a purchase might actually keep that hospital afloat. But I think that is the exception, not the rule.

Senator CASSIDY. I am out of time. I should yield back, but I please ask you to look at my whitepaper and give me feedback.

Dr. JHA. We will. Thank you.

Senator CASSIDY. I yield back. Thank you.

The CHAIRMAN. We will come back to you in a second round, Senator Cassidy, if you would like to.

Senator Smith.

Senator SMITH. Thank you, Chairman Alexander.

I have to say this is just a very interesting panel. I am so grateful for all of you being here.

I do not know if I am going to have enough time to dive-in to this, but I appreciate, Senator Enzi, you raising the issues around rural health care, because it is extremely important in Minnesota. Potential next steps in some ways are not obvious, based on the broader issues that we have in this country around health care costs.

But I would like to actually focus in on prescription drug prices, which is something that I hear about all the time in Minnesota.

I had a roundtable with a group of people in Minnesota a couple of weeks ago and there was a mom there whose daughter has Type 1 diabetes. She and her husband and her daughter had traveled all over the world. It was so interesting.

She pulled out the insulin pens. In Taiwan, she said she paid \$8 for that insulin pen. In Canada, she paid \$13. In Greece, she paid \$10. In Israel, she paid \$11. In Germany, it was \$14, and so on.

But then in St. Paul, Minnesota, where she lives, she paid \$140. Interestingly, around the world, she did not even need a prescription much of the time.

\$140 versus, say, \$13. This is, for her, not an abstract challenge. This is, "How do I pay for my daughter's health and pay the rent?" kind of challenge.

Dr. Jha, can you give us two or three things that we could do, sooner rather than later, to address this problem?

Dr. JHA. Thank you, Senator, for that really important question.

I had a similar experience. I was in Europe and my briefcase was stolen with my own prescription. I walked into a pharmacy in Paris and paid 90 percent less for a generic pill than I was paying in Boston. So this is an experience, I think, any of us who have traveled abroad have had.

Look, I think the prescription drug issue needs to be split up in a couple of ways. You brought up the issue of insulin. Insulin is not a new innovation that we just discovered and we want to pay for that innovation.

There are innovations where we can talk about whether the \$100,000 for a new cancer drug is worth it or not. That is not the insulin conversation.

Senator SMITH. That is not what is going on here. And it has gone up 300 percent, on average, I understand in the last 3 years.

Dr. JHA. Exactly. And so, we have to separate these two issues between what I see as innovation for new treatments where there is a debate to be had about what are the tradeoffs we are willing

to live with as a society. And what I think is just plain old market power and manipulation of the fact that often in generic markets, there is one provider.

Senator SMITH. Right.

Dr. JHA. When you are a monopoly, you can charge more or less whatever you want. So I think this is a place where there is a series of policies that can be implemented.

I believe that for things like generic drugs, we should look seriously at, for instance, importing drugs from other countries. I mean, imagine that insulin that is approved in Germany. Would any of us really feel uncomfortable taking it because the German authorities have signed off on it?

Senator SMITH. Well, and it is exactly the same product, the same manufacturer.

Dr. JHA. Exactly the same.

Senator SMITH. Probably manufactured in the same place.

Dr. JHA. Yes. So I believe for certain things, we have to take a different approach to dealing with competition, encouraging more competition.

One of the ways prices get kept down in every other industry is through international competition. We live in a global market. Health care is the one place where that has struggled.

Specifically around generic drugs, I think we need to look toward more competition as a way to drive prices down.

Senator SMITH. Did you see any of those ways of increasing competition dealing with what we have, as in many markets, a monopoly that allows these big drug companies to basically charge whatever they feel like charging? Did you see any recommendations to address that in the President's blueprint?

Dr. JHA. I have not paid very close attention to the President's blueprint on drug pricing.

Senator SMITH. I did not. I have just a minute more and I would like to raise this question of pricing transparency.

I really appreciate what Senator Collins was raising about linking up quality and cost. In Minnesota, we have something called Minnesota Community Measurement, which is a multi-stakeholder group of payers, and providers, and employers, and policymakers all who have come together to create a data base of costs and quality data.

Maybe, Dr. Buntin, just in the few seconds that we have, could you tell us a little bit about whether you think systems like this can make a difference? How can we make them more accessible to people?

Dr. BUNTIN. Thank you for that question.

I do think it is important when we talk about price transparency to look at the best examples of tools. This was something that Niall Brennan addressed in his testimony.

Just presenting people with prices alone does not seem to change their behavior much. There has been ample research on this subject. So we need to look ahead and figure out what will work.

I do think that one thing that is nice about Minnesota, is that there is a combination of some price and quality information; that is a step. And I think it can be tailored down to the level of providers; that is an additional step.

Perhaps a third and fourth step, for example, is asking people what insurance they have? Where they are relative to their deductible? Really having the types of details that people need to make decisions.

But fundamentally, I think that research has shown it is very difficult to get people at the point and time when they are ill and need a service to do a lot of comparison shopping.

Senator SMITH. Yes.

Dr. BUNTIN. We cannot rely on just one thing. It may help, but it is not the silver bullet solution.

Senator SMITH. Thank you so much. I know I am out of time, but I will follow-up with others on that issue, because I am interested in all your perspectives.

Thank you.

The CHAIRMAN. Thank you, Senator Smith.

[Chart.]

The CHAIRMAN. I do not want to be outdone by Senator Cassidy, so I have my own chart.

[Laughter.]

The CHAIRMAN. My question is, what do we do about this?

There was some talk, two of you said, "Well, Medicare is under a little bit better control," in terms of prices than other health care costs. But if you are a United States Senator, you are confronted with this.

This bottom line is one-third of the Federal budget. It has gone up at about the rate of inflation for the last 10 years and over the next 10 years, according to the Congressional Budget Office, it goes up at more than the rate of inflation.

In other words, it is not breaking the bank. It is not busting the budget, and it is very important things. More than half of it is national defense. The National Institutes of Health, Senator Murray and Senator Blunt are about to put us into the fourth consecutive year of \$2 billion a year increases on biomedical research. I mean, we are pretty excited about that.

Then National Laboratories, those are secret weapons and competitiveness. And then, National Parks, President Trump, and Senator Portman, and Senator Warner, and others, we have a bill to really do some things with the National Parks. We have that all under control even though it is priority spending.

This is two-thirds of the budget. It is Medicare, Medicaid, and Social Security. Medicare and Medicaid are the biggest parts of it and they are allegedly under better control than other health care costs.

This is going to wipe out this if we do not do something about it.

Do you have any comment on what a United States Senator should do about that red line?

Dr. BUNTIN. Thank you, Senator Alexander. I would love to take that on.

Having been in the Great Smoky Mountains National Park near your hometown this past weekend, I can tell you that I love that and the National Institutes of Health, and I like to see that blue line rising.

I think this relates directly to the types of things I talked about, and that when I was at the Congressional Budget Office, we tried to educate Congress about it year after year.

The key determinant of that red line rising is that rate of growth in health care costs. In particular, the Congressional Budget Office generally tries to emphasize how that is affected and how much of our Gross Domestic Product, or a national output, health care will consume.

They focus on the extent to which health care costs per capita grow faster than productivity as a whole; the set of taxes that we use to fund our government.

That is where, when I was emphasizing that we need to keep an eye on prices paid to providers in our public programs, and where we need to keep emphasizing that we are serious about paying for value, and we want to see investments made by providers that will yield higher value care. That is where, I think, we have to keep the pressure on.

The CHAIRMAN. Within my time, let me go to Dr. Jha and something he said. You mentioned waste, fraud, and abuse. We always make speeches about that.

I have tried to get CMS and the National Laboratories to hook up on that.

But another area is administrative burden. You said that could be, or Dr. Hyman said 25 or 35 percent of the total. That is a massive number.

Are there specific things Members of Congress can do about administrative burden as a way to reduce the growth of this red line and other health care costs?

Dr. JHA. Thank you for your question, Senator.

Let me just say one quick thing on the red line, kind of more generally. There, if you ask the question, "What does the evidence tell us today about things that lower health care spending growth in the Medicare population?" There are a couple of things.

Accountable Care Organizations seem to be making a difference. Again, changing the way that we pay for health care. Medicare Advantage has seen phenomenal growth over the last 10 years and we see that having a dampening effect on health care spending growth.

There are things that have actually made a difference.

The CHAIRMAN. That helps to reduce the growth of health care.

Dr. JHA. Reduce the growth of health care spending in the Medicare population; so the red line.

The CHAIRMAN. Because the beneficiaries pay part of it?

Dr. JHA. No. So ACO's have done this, Accountable Care Organizations have done this primarily by preventing unnecessary hospitalizations.

Medicare Advantage has done this through a variety of different means, which we do not actually understand very well because those data are not available yet to researchers. CMS has said they will make that available.

But the evidence is very clear that M.A., Medicare Advantage is having a dampening effect on health care spending growth. Not only for its own beneficiaries, but it is also spilling over on Medicare fee for service beneficiaries.

There are things that are working and I think we should encourage more of that.

On administrative costs, a lot of those administrative costs fall on the private side, on private insurance, though we do think that there are administrative costs—

The CHAIRMAN. Such as?

Dr. JHA. Well, so if you go to the private side, as a physician if I am practicing in a hospital—and I work at a V.A., so it is different—but when I was working at a Partner hospital and there were six different insurance companies, every one of them credentialed me separately.

The amount of spending that goes into that repeat is wasteful. And so, there are proposals to say, “Can we just do, you get credentialed once and then other insurers take that credential.”

There are those kinds of ideas that are simple. As I said, they do not hurt innovation. They do not hurt quality, but they save the system money. There is no shortage of ideas.

The CHAIRMAN. My last question, to what extent is Electronic Health Records’ growth over the last few years added to the burden?

Dr. JHA. Yes, so this is an area I followed very closely.

It is a little bit painful because I have been one of the big advocates of Electronic Health Records and believed that it had the opportunity to have a big, positive impact on our health care system. I remain hopeful that it will.

But the way we have done it, it is undoubtedly clear that the physicians and nurses of our country have borne the brunt of that. What that has meant is for physicians spending hours a day longer charting.

That does not necessarily show up in the red line, but it does show up in burnout rates. It does show up in other negative ways toward the health system and we have to do better on that.

The CHAIRMAN. Thanks, very much.

Senator Kaine.

Senator Kaine. Thank you, Mr. Chairman.

To the Chairman and Ranking Member, what a wonderful hearing.

In Virginia, my constituents have just been reading newspaper articles about health insurance premiums going up, and the companies are pretty blunt about why, and they are laying it at the feet of the uncertainty that this Administration is putting into the health care market.

President Trump actually bragged about it. He was giving a speech in Nevada this past weekend. He criticized Senator McCain for his vote not to repeal the Affordable Care Act. This was his quote. President Trump said, “It is all right because we have essentially gutted it anyway.”

I hope we will all try to take steps to not make it worse. I think this hearing is about strategies and information so we can make it better.

One question I want to ask you for the record, and then I have one that I really want to talk to you about is it is interesting that in your testimony, I do not see a lot of discussion about health.

I used to always challenge my own HHS Secretary when I was Governor, “Before you talk to me about health care, talk to me about health.”

I want to ask you for strategies. I think one of you said we do a better job of managing illness than we do managing or promoting health.

I want to ask for strategies where we can promote health, which should have an effect on health care costs, as well as leading to a better quality of life.

I want us to be the world’s greatest deliberative body that the Senate often says we are. I think a hearing like this helps. I think that there are a couple of big ideas on the table that I hope this Senate might contemplate.

Senator Cassidy has a big idea. It is a big idea and I do not want to try to describe it. He would do a better job of describing it. But his bill with Senator Graham, that is a big idea about doing things differently.

Senators Sanders and Warren have a big idea, the single payer model.

Senator Bennet and I have a big idea. We call it the Medicare-X.

Just picking up, Dr. Buntin, on your testimony and others, about slow cost growth in Medicare, our idea is basically this: ask CMS to develop an insurance policy that would cover the Obamacare Essential Health Care Benefits and put that on the Health Exchanges so that an individual can purchase it.

CMS would have to cover, through premium collection, the cost of this policy, so it would not increase the debt. It would not increase taxes. It would not touch the Medicare Trust Fund.

But the idea behind our proposal is Medicare has a low administrative cost burden, not the administrative complexity, Dr. Jha, that you are talking about.

They already have a distribution network. They already have a fee schedule. They already exist in every ZIP Code. They do not have to cover a profit margin. They do not have to return to shareholders. They do not have to pay state, and local, and Federal taxes. They do not have to advertise on the evening news because everybody knows that there is Medicare.

If you put that one item into the current system on the individual exchange, people who qualify for an Obamacare subsidy could use that subsidy to buy down the premium cost of Medicare-X. Or they could say, “I like my policy just fine. I like my private policy. I am going to stick with it.” It would just be the injection of a competition, an additional choice.

Senator Bennet and I talk about doing it first in communities that only have one option on the exchange for individuals.

I hope we will get to a day—because I am sure there are really good things about my proposal and I am sure there are some challenges—but I would love to have a time after we finish hearings on cost where we put Medicare-X on the table, with Senator Cassidy’s proposal, and with Senator Sanders’ one single payer proposal. And we will hear from witnesses about what they like and what they do not like about each.

But I am just struck, and I have been struck over and over again, by the positive track record in Medicare in doing what Dr. Buntin, you said our focus should be. Which is, if we cannot scale back the 18 percent—it might be unrealistic to think we can without shedding all kinds of jobs—at least we ought to be trying to control the growth of costs, and at least we ought to be trying to control the growth of premiums and other out of pocket costs that our constituents experience.

If any of you have any thoughts about that, I would love to hear it.

Mr. BRENNAN. Well, I think specific to your notion of getting to a culture of health as opposed to treating sickness, it is really important.

Again, it boils down to incentives, not just for providers who are currently incentivized to treat people when they are sick and not necessarily keep them healthy.

But also for consumers, there are so many roadblocks in the way, just the little everyday frictions and hassles of the health care system, and finding the right primary care doctor that will see you at the right time. So we need to remove barriers for both patients and providers to promote a culture of health.

Dr. JHA. Just very quickly, Senator, two quick points.

One is so much of what determines health happens outside of the doctor's office. And so, we need to think about health much more comprehensively.

If you want to prevent hospitalizations for asthma, you have deal with air pollution. Right? If you want to prevent obesity, you have to think about food policy.

The reason my testimony focused on health care is because that is what is gobbling up \$3.3 trillion of our national income. But nobody that I know thinks, "What is the best way to spend that money to improve the health of the American people?" So I think we do have to take that on.

On the suggestion that you brought up, Senator Cassidy's idea, the broad principle, I would say, is we need a lot more experimentation than we have right now. There are good ideas on both sides of the political aisle and we have to be able to try them out. Some of them will work and some of them will not work. But instead of predicating it on, "Well, we already know what the impact is going to be," we do not. We should be trying out more things in our health care system.

In many ways, our health care system looks like the system that was designed in 1965, and the world has changed, and we need a health system that also changes with it.

The CHAIRMAN. Thank you, Senator Kaine.

Now, we will begin a second round for those Senators who would like to do that. Senator Murkowski may be back.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

I just have one focus. Dr. Jha, I wanted to ask you. You talked about the problem of patients going to in-network hospitals, but being surprised by expensive bills when it turned out that some of their physicians were out of network.

In addition to that problem, Mr. Brennan noted that emergency room care is growing more expensive and some insurers now are adopting policies in which they refuse to pay for, quote, “unnecessary emergency room visits.”

What factors are leading to these high unexpected bills we are hearing about?

Dr. JHA. Yes, so I think both of those are really substantial problems and the best estimates are that about 14 percent of the time, so one out of seven times, when somebody goes to the emergency department, they are going to be stuck with a surprise bill.

Senator Alexander, the example you used of the gentleman from the great State of Tennessee. This is not a rare example. This is becoming more and more common.

Senator MURRAY. One of seven times?

Dr. JHA. There are some estimates that 14 percent of the time, or 1 out of 7 times when somebody goes to the emergency department, they may get a surprise bill. So that is a very high number if it turns out to be true.

Even if that is double the true number, these are just astronomically high numbers that a lot of Americans are experiencing.

The business model that leads to that is there are hospitals that have trouble staffing their emergency department. A private company comes in and says, “We will staff it for you and you do not have to pay us a cent and we will be here 24/7.” The hospital says, “That seems like a good idea,” and then all their physicians are out of network and that is how they make their money.

Senator MURRAY. What kind of policies should we do to make sure people do not say that?

Dr. JHA. I think this is an outrage. I think this is, I mean, it is unethical if not illegal. Obviously, it is not illegal, but it ought to be.

States can do a lot on that and about 21 states have begun to address this. I think six states have actually done something useful on this, which is basically put in policies that say, “If you do out of network billing for things like emergency department, hospital care,” you essentially—

There’s a bunch of ways you can do it. You hold the patient harmless. You do not do balance billing to the patient. You have to go through some sort of a negotiation process with the insurer. Some states have put in policies that you essentially get some multiple of the Medicare rate.

The bottom line is there are lots of good ideas out there from a policy point of view. States have a big role, but actually, the Federal Government has a big role because, of course, a lot of patients get their insurance through their employer. I mean, actually a lot of people get it through an employer, but employers are self-insured. And so, because of ERISA, they do not fall under the same state mandates.

I think the Federal Government also has a role here in putting in policies that say, “We will not allow for this surprise billing and it should not go to the patient,” and that there has to be a mechanism by which that gets resolved between the insurer and the provider, and the patient is not left with this unexpected bill.

Senator MURRAY. Yes, and that goes to the person I talked about in my opening statement too, who did her homework—

Dr. JHA. Yes.

Senator MURRAY. —and thought she was going to get covered by insurance. How would she know to ask every single person that came? The anesthesiologist? She had no idea.

Dr. JHA. No. It is insane to expect it and even when the consumers do their job, they are still stuck with this.

Very quickly, on your emergency department issue of not paying for it. There is actually very good evidence that it is very easy in retrospect to figure out what was an unnecessary emergency room visit. Right?

I develop chest pains. I go to the emergency room. It turns out, it was heartburn. Well, that was unnecessary. Well, if I knew that I would not have gone to the emergency department.

Senator MURRAY. We are told to go to the emergency room.

Dr. JHA. Yes. So I think that policy sounds good on paper. It will not work. It will prevent people who need to go to the emergency department—

Senator MURRAY. From going.

Dr. JHA. Then it will stick a lot of people with unnecessary bills.

These are not our solutions to our health care cost problems. These are just ways of saddling sick people with bills that are not good for them. This is a place where, I think, policymakers can make a big difference.

Senator MURRAY. Okay. Thank you very much.

Dr. HYMAN. Senator Murray, there is a chapter in the book about this particular problem. It is full of stories of people who found themselves in this situation through no fault of their own.

Probably the worst is the patient who gave birth in a hospital and then discovered that the NICU was out of network, which is just crazy.

The underlying problem here is a lack of adequate competition and disclosure of information. The solutions that the states are looking at are band-aid responses to the underlying problem.

If you went to a body shop to have your car repaired, the paint, the man who painted it would not send you a bill 3 weeks later on the theory that he was out of network. You would never go to the body shop. You would write a mean review about it on Yelp and no one would ever go there again. The employer would fire the painter and reorganize their operations.

The patients are stuck in the middle, but it is a problem of inadequate competition and inadequate information.

Senator MURRAY. Okay. Thank you all very much. Appreciate it.

The CHAIRMAN. Where is that book you promised, Dr. Hyman? Do you have enough for all of us?

Dr. HYMAN. I will have it sent over.

The CHAIRMAN. Okay, good. We had the same example from our respective states, actually, without any prior collaboration.

Senator Cassidy.

Senator CASSIDY. Dr. Hyman, you have worked with the FTC, I understand. Your testimony refers to the consolidation that has occurred in the industry, and Dr. Jha and I spoke of Partners in Boston.

Now, I remember 8 years ago reading a report that 64 percent of the major metropolitan areas, already 8 years ago, had consolidation that would normally have violated antitrust rules.

Has the FTC been asleep at the wheel?

Dr. HYMAN. Senator, I was proud to serve at the Federal Trade Commission from 2001 to 2004 looking at these issues of health care competition policy. That was when the FTC launched the merger retrospective that culminated in the challenge to the Evanston Hospital merger.

The reality is there have been a whole series of challenges to collusion among physicians. There was a series of challenges to hospital mergers that were mostly unsuccessful. The merger retrospective was an attempt to try and figure out, (A), why that had happened. And (B), evaluate consummated mergers to see whether they could come up with actual evidence of post-merger pricing increases that would be persuasive enough that they would be allowed to unwind the merger.

The difficulty with unwinding a consummated merger should not be underestimated. Well, there is a matter of proof.

Senator CASSIDY. I get that.

Dr. HYMAN. Yes.

Senator CASSIDY. I can totally intuitively understand that, but if 8 years ago, 64 percent of them were consolidated and it has only gotten markedly worse since.

Dr. HYMAN. I was about to get to, I do not know the current figures and I am not sure of the specific study you are talking about.

One of the challenges is whether antitrust—because of unfavorable precedent, or hostile Federal judges, or inadequate resources—has been up to the task.

Senator CASSIDY. What you are suggesting is under status quo, it would be difficult to prevent. And if we were going to prevent it in the future, it may require legislative action?

Dr. HYMAN. I have not thought enough about that to give a response to that. I think the additional challenges I want to highlight is Federal payment policy can also encourage consolidation.

Senator CASSIDY. I totally get that.

Dr. HYMAN. You might want to look closer to home.

Senator CASSIDY. Look at my white Blackberry. Just send me a note, will you?

Dr. HYMAN. I would be happy to do that.

I would also note my coauthor, Charles Silver, sent you comments on your proposal that I subscribe to.

Senator CASSIDY. On the price transparency?

Dr. HYMAN. Yes.

Senator CASSIDY. Now, let me ask you as well, the price transparency, I understand in your book, I am told that you have some comments on the interaction between Health Savings Accounts and price transparency.

Can you very briefly, because I have another question for Dr. Jha, can you address that?

Dr. HYMAN. Yes, it is extremely foolish to expect that price transparency will have any effect on people who are not at-risk for the financial consequences of where they go. They do not care. They

are not at-risk. So telling them information about pricing is not going to have an impact.

To the extent that they are actually using information on pricing to assess quality, as Dr. Jha has previously alluded to, it will actually do exactly the opposite of what you might want them to.

If you want high deductible health plans, or Health Savings Accounts, or greater first party payments to work, we need to do a much better job at getting better information to consumers about, “If you go here, here is what it is going to cost, and here is the quality. And if you go to this other place, here is the difference.”

Now, in private markets, for everything else, we see that. So if you watch the ads for cars on television, nobody has to force them to tell you what the price is.

Senator CASSIDY. One thing I have been struck, “Consumer Reports” did a secret shopper of generics and they found between pharmacies, the price for the same generic ranged from \$44 to \$700. I think I remember that correctly.

But so, I think you would also suggest that if we are going to have price transparency, the price should be pushed out. It should not just be something you have to learn by knocking on the door.

Is that, again, a fair statement?

Dr. HYMAN. I agree with that. I think we ought to have widely available information. You should only expect that the people who care about it will go and look for it, but we should not make it so hard for them to get it.

Senator CASSIDY. Dr. Jha, I am struck. You spoke very favorably of the ACO’s. It is actually to me, the evidence I have seen is that if you take out McAllen, Texas, which was already so high, that some of the places really have not achieved savings. It has actually been flat.

Now, if you read Atul Gawande’s follow-up on McAllen, it actually seemed like the M.A. plans were actually more responsible for lowering cost than the ACO. You are nodding your head. It seems as if you might agree with that.

Dr. JHA. Yes. So look, when you look at the sum of the evidence on ACO’s—and the best work on this has been done by a colleague, J. Michael McWilliams, M.D.—it has probably reduced spending growth by 1 to 2 percent over controlled practices in those communities. That is not a home run.

Senator CASSIDY. That is weighted somewhat to, again, the McAllen’s, which are already so high that they had no place to go but down.

Dr. JHA. Yes, and the key here is that it is your early ones who have had a bunch of years that have done it and it has been the independent practices that have seen to have actually saved money.

Senator CASSIDY. Let me go back to that.

Dr. JHA. Yes.

Senator CASSIDY. Because one thing as a physician speaking to a physician I have found that you need a beneficial relationship between patient and doctor in which there is both an interest in the health, but also the financial health, physical financial, for you to truly achieve savings, in that way you can. Whereas opposed to the

patient on their own trying to figure out the cheapest place to get the best colonoscopy.

Dr. JHA. Yes.

Senator COLLINS. It is actually the doc saying, "Listen, if you go here, you are going to get best and best." Would you agree with that?

Dr. JHA. Yes.

Senator CASSIDY. Dr. Buntin, you are nodding your head yes as well.

Dr. JHA. I would, and I think what we have seen so far, as again, speaking physician to physician, I think we as physicians have not done a good enough job.

Senator CASSIDY. I would disagree with you a little bit when it comes to M.A. because physician-run M.A. plans precisely are that paradigm.

Dr. JHA. Yes, M.A.'s are, but as a general, I think, physicians have not done a good enough job of steering patients toward lower price providers. So I think that is a real challenge.

I agree, I am in a high deductible health plan. I find it unbelievably hard to shop, and I feel like I should be a reasonably good shopper being a doctor, being a health policy person, I cannot figure it out.

Senator CASSIDY. You are suggesting that Federal legislation regarding price transparency may be important.

Dr. JHA. I think it is really important. It has to be coupled with other things like competition in the marketplace because I think without competition, transparency alone will not get us there.

Senator CASSIDY. I am way over time. Thank you for your forbearance.

The CHAIRMAN. Thanks for your good questions.

Well, thanks to all of you. I am going to conclude, unless Senator Murray has something else, with a political question. We are supposed to be the politicians, but you have all either participated in the government or examined it carefully.

Let me get my chart back up here.

[Chart.]

The CHAIRMAN. There has been some talk about how Medicare costs are better than some other health care costs, but look at that red line going through the roof.

Even the most recent report by the CBO, which one of you used to be at the CBO, Medicare trustees say the Trust Fund will be insolvent by 2026, 3 years earlier than they projected last year. Medicare spending is still unsustainable.

Where does all of this lead us? Obviously, this cannot continue forever. Now, President Obama did not tackle it, that part of it. Congress huffed and puffed and did not tackle it during President Obama's time.

President Trump has said he is not going to tackle it, this part up here. Republicans are not courageous about Medicare, Medicaid, and Social Security. Democrats are not.

What event do you suppose will cause the Government or the country at large to take steps to bring the growth of health care spending under control? Do you suppose this unsustainability of Government programs might cause it? Or do you think it will be

something in the marketplace other than that? Or do you have any idea at all what might bring us there?

Dr. Buntin.

Dr. BUNTIN. I am so glad you asked this. If this hearing had been held 10 years ago, the forecast of the actuaries was that the hospital insurance trust fund would be bankrupt already.

What has happened since then is that we have really had, while the Baby Boom has been retiring, costs have been going up, but on a per person basis, they have been going up more slowly than we would have ever guessed a decade ago.

Luckily, on that red line that you are showing is increasing very steeply in the future. Part of that, we cannot control because the Baby Boomers are aging and they will be eligible for Medicare.

But if we can stay the course on the things that have kept per person costs down in Medicare, then I believe the trajectory of that line will be bent down.

The CHAIRMAN. Dr. Jha.

Dr. JHA. First, I am reminded of an old Yogi Berra-ism that predictions are hard, especially about the future.

Look, that graph is scary but my point is that we do not know what the future holds because a lot can change and I think what we need to see in order to enable change—

Let us say that graph is right. Let us say we are heading toward a cliff. What do we do? I do not think the solution is—not only is not politically feasible, I do not think morally it is right—to dramatically scale back programs and leave people uncovered. I think that has a political cost. It has a health cost. I do not think that is where we want to go.

I believe that there is nobody I know who has all the answers, and what we need is a lot more experimenting. We need new models. So again, I do not think 10 years ago, anybody predicted that M.A., Medicare Advantage, would grow as much as it has and that it would have the kind of impact that it has had, a beneficial impact in slowing health care spending.

I would like to see, Senator Kaine brought up three different ideas. I would like to see us experimenting with new approaches, new models.

The only thing I will add is we need to connect the dots with people that when more and more money goes into health care, that means less money for education, less money for the National Institutes of Health, less money for our national parks.

The CHAIRMAN. That's what I try to do with that.

Dr. JHA. I know, which I think is brilliant, but we need to connect the dots for the American people so they understand that there is no free lunch here and that there is a lot of policy experiments we can do to drive this agenda forward. We have to do it because the cost of inaction is too high.

The CHAIRMAN. Mr. Brennan.

Mr. BRENNAN. I think it really is a difficult question. I have been doing this for a number of years now and when health care spending hit 12 percent of the GDP, people said, "This is totally unsustainable." When it hit 15 percent, people said, "Well, now it is really unsustainable." And now we are at 18 percent with projections to 20.

To echo some of the comments by Dr. Jha and Dr. Buntin, we need to start figuring out what are we not getting because of the amount of money we are spending on health care. Maybe that will be a triggering event or maybe in 5 years' time, we will be sitting here saying, "No. When it gets to 30 percent that is when it is really, really going to be unsustainable."

The CHAIRMAN. Dr. Hyman, you can have the last word.

Dr. HYMAN. I first want to thank the Committee, again, for inviting us and echo the comments of my fellow panelists.

Let me close with two quotes, one from Peter Fisher, former Under Secretary of the Treasury in 1992 when the numbers were much less impressive than the ones even on the left side of your figure.

What he said was, "Think of the Federal Government as a gigantic insurance company with a small sideline in national defense and home security."

[Laughter.]

Dr. HYMAN. We continue down that trajectory with an excess rate of growth in health care relative to the rest of the economy driving the red line upwards and projections about how bad it will be, either making it really awful or just bad.

The other quote I want to leave you with is economist, Herbert Stein, who said, "If something cannot continue forever, it won't." And so, maybe that is the only good news is eventually, we will muddle our way through to something other than where we are now.

Thank you very much.

The CHAIRMAN. Well, thank you, very much.

I think Senator Murkowski wants to come back, but she is not here yet. Does anyone know? We will wait just a moment and see if she literally is on the way, or whether that is just a rumor that we have heard in the hall.

[Pause.]

The CHAIRMAN. We may resort to an old fashioned telephone and actually call and see. Everybody under 35 does not do that anymore. They just use their thumbs. Here she is.

Senator Murkowski, you are going get to have the last word.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I apologize that I am keeping you late, but I want to let you know how much I appreciated the panel.

Just a moment ago, I was with our Governor and had a chance to share some of the thoughts that we face on our health care costs. As you know, in our state, very high, very challenging, and we have struggled to find some solutions.

I wanted to ask a question that may seem to be a little bit parochial, but I have such an extraordinary panel in front of me. I feel if I do not take this opportunity, it would be lost.

Back in 2004, Alaska put in place something that is called the 80th percentile rule. Are any of you familiar with that?

Okay. The 80th percentile rule sets a minimum for how much insurance companies have to pay when Alaskans with private insurance plans go visit doctors or other providers that are out of network.

What the rule does is it requires the insurers to base their payments for out of network claims on the amount at, or above, 80 percent of what all the providers charge for a specific service in a given area of the state.

There was a study that was conducted by the University of Alaska there at the ISER, which is the Institute of Social and Economic Research. It was just completed about a month ago. It found that the rule contributed to anywhere from 8 percent to nearly 25 percent of the annual growth in spending.

The headline in the newspaper, after the report was laid down, attributed \$85 million to state health care spending directly attributable to this 80th percentile rule, which, of course, gets everyone's attention. They said about 22.5 percent could be attributed to the rule.

One of the complicating factors that we have in the state, and Senator Enzi mentioned it as well, as the rules state, you have few specialists. So you essentially have a few number of providers that are effectively setting the rate for the entire state.

The Division of Insurance is looking at this considering whether or not making changes are appropriate, possibly even eliminating it entirely.

I bring this up because it is something that is unique, I understand to Alaska, but it was also designed to deal with—what Senator Enzi has raised, what other rural states deal with—with a lack of specialists.

I would like your comments, if you are able, but also recognizing that we have a situation where we do not want to leave our emergency providers basically holding the bag if folks are brought into the emergency room because they are out of network situation.

Again, I apologize for the very parochial nature of this, but again, when you are looking at something that we have experimented a little bit with to see if we cannot reduce our costs, and now we are finding that we have gone the other way.

Can any of you comment? Dr. Buntin and Dr. Jha, both of you are nodding your heads. Can you help me because we are looking for some advice here?

Dr. BUNTIN. Well, it does sound like unintended consequences which come into policymaking so often. This is an issue that was brought up in the opening remarks by both Senator Murray and Senator Alexander. What do people do about out of network providers and these surprise bills?

This is a seemingly logical step to take to say, "We are going to limit those out of network prices to 88 percent." The situation in Alaska is that the population distribution is so sparse, there are so few providers that it just might make economic sense for a provider to just take the 80 percent of whatever the highest rate is available in the state.

Senator MURKOWSKI. Right.

Dr. BUNTIN. Maybe that worked at first, but now it is a situation where the insurers are having difficulty getting the providers to the table to negotiate rates that are lower.

It might be the type of situation where it is good to seek external reference prices.

Senator MURKOWSKI. Out of state?

Dr. BUNTIN. External prices to reference, so external, perhaps, to the state or perhaps Medicare prices. This is an idea that Senator Cassidy brought up. I do not remember if you were in the room at the time.

Those are possible solutions.

I am certainly not an expert in this area and perhaps Dr. Jha is going to comment on it, but there are 20-some-odd states that have been facing this problem and trying to look for other solutions. It is possible that some of us can look into that and get back to you about whether any of them have come up with solutions that might work given your unique circumstances in Alaska.

Senator MURKOWSKI. Thank you.

Dr. Jha.

Dr. JHA. Let me just add that there are a couple of problems that are contributing to this, and one of them is we have talked about the importance of competition. What you have highlighted, Senator Enzi highlighted.

It sounds great on paper, and in lots of places it works, but in large parts of Alaska, it is going to be a challenge. And that, of course, makes sense.

But actually, we heard earlier that there are some things that we can do to try to improve access and can actually help with competition a little bit, such as greater focus on telemedicine. I actually think Alaska has been doing a lot in this area.

Senator MURKOWSKI. A lot.

Dr. JHA. But we could do more still. Medicare is another, is something that can push this a bit more than it has in terms of how it pays for these things.

There are policies that we can put in to try to create a little bit of virtual competition when real competition is hard, but that does not get away from the problem that you have highlighted.

It is very interesting because when you first described the 80th percentile rule, my first thought was, "Well, that seems pretty reasonable." And then as you described the impact of that, I realized, "But in this case, it will not work."

What other states have done is they have said things like, "If you go out of network, you are getting a certain percentage of Medicare." So you might get 110 percent of Medicare as your payment and that changes the incentive because you are no longer referencing to the highest priced guy in your community. Now you have a national number to deal with and that is more likely to bring providers into the conversation with insurers to be in network.

That is what I believe about six states have done in terms of this. I am happy to work with your staff to get you more detailed information, but this is a complicated problem, but I think we can make progress in this area.

Senator MURKOWSKI. Well, I appreciate that and I would like to follow-up with you.

Let me ask one more quick question, if I may, Mr. Chairman and I will be very brief, but the administrative burden that you have raised, Dr. Jha. Clearly, I think it is a reason for some of the higher prices. Others say that consolidation drives the prices.

But I have heard from several of our hospitals and doctor groups that it is the administrative burden that is driving the consolidation. In some of our smaller communities, it just does not work.

Small practices just cannot afford to bring on the folks to deal with the billing, to deal with the insurance companies, to deal with Medicare and Medicaid. They cannot deal with it. And so, they have to find their efficiencies of scale.

Would reducing the administrative burden also reduce the trend of the consolidation that you have suggested and effectively work to protect patients from rising costs?

Dr. JHA. The evidence on this is that the average physician has somebody working in his or her office about 15 hours a week just to do reporting on quality data, et cetera.

If you think about a three physician practice, you are hiring close to two, full time people or one and a half full time people just to manage all the administrative requirements. That is not even your own administrative time.

What happens more and more is hospitals show up and say, "We will buy out your practice. We will do all of that for you, and you just practice medicine." Sounds pretty good.

I do think that these two trends, that I actually kept separate in my own testimony, I think you have done a very important job of linking the two and reminding us that these are not separate phenomena, and one of them may actually be feeding into the other.

We have to look much more sharply, much more closely at the administrative challenges that physicians face because it does make them much more susceptible to just giving up that part of their practice, becoming an employee, and consumers are not necessarily helped by that.

Senator MURKOWSKI. Do you have any answers to that yet?

Dr. JHA. Well, so I think we have to look at different quality measures, for instance. If you are employing somebody 15 hours a week on average, we have to get to electronic quality measurement.

I mean, the idea that you hire a nurse to go through your chart and document stuff and file it, we are in 2018. We should be able to do this electronically. So we have to push the Electronic Health Record to make this stuff much more streamlined and much more efficient. So I think that is one place where we can make some progress.

Dr. HYMAN. Senator, I would just add, first of all, the perhaps apocryphal story is that Duke University Hospital has one and a half billing clerks for every bed that it has. So one of my friends checked in and said, "Where are my one and a half billing clerks?"

But the caution I would add is unless the market is competitive, even if you succeed in lowering administrative overhead, it does not follow that prices will drop. So you need to attend to both of those things.

Competition has been highlighted repeatedly, but it is important to recognize even if we cut administrating overhead in half, providers could pocket that unless they were competing with one another.

Mr. BRENNAN. I think specific to the issue of the acquisition of physician practices by hospitals and hospital systems, that can ac-

tually have an inflationary effect on spending because if something that was one price in a physician's office is now a higher price because it is being covered through a different hospital payment system.

Senator MURKOWSKI. Mr. Chairman, thank you. You have been very, very generous.

I thank the panel for your help. I look forward to following up with you.

But thank you, Mr. Chairman, for holding this over so much.

The CHAIRMAN. Thank you, Senator Murkowski. Thank you for making the effort to come back.

Well, thanks to the four of you. This has been very helpful to the Senators. You obviously know what you are talking about, which we recognize when we see it, and we appreciate it. So thank you for your time and your wisdom, and if you have more to say to us, we would welcome it in writing.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time, if they would like.

The CHAIRMAN. We intend to hold three or four more hearings on reducing the growth of health care costs. One of those will be focused on the administrative burden.

Thank you for coming.

The Committee will stand adjourned.

[Whereupon, at 12:03 p.m., the hearing was adjourned.]