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ARE U.S. HEALTH CARE PRICES TOO HIGH, TOO LOW, OR SOME MIX OF THE TWO?

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P R O C E E D I N G S

MR. GINSBURG: Hello, I'm Paul Ginsburg, director of the U.S.C. Brookings Schaeffer Initiative for Health Policy, and I'm pleased to welcome you to the first of three webinars focused on Potential Public -- Public Regulations of Health Care prices. Although the COVID-19 pandemic has consumed much of the health's policy space, based on recent months, our Nation will need to return to the issue of the burden of high service prices, for health care in the United States.

In three biweekly seminars, we will be exploring the issue of whether or not prices in the U.S. are too high. What are the tools that the U.S. public sector can utilize to address high prices, and what tools, used in other advanced countries, might be applicable to the United States? A very important voice in raising concern about the issue of high service prices was the late Uwe Reinhardt, who wrote and spoke about these issues extensively.

He's particularly well-known for his classic article on health affairs called, "It's the Prices, Stupid", and for his recent book, called "Priced Out", which was published last year. These webinars are being conducted in his honor. I have the privilege of knowing Ewe well, for over 40 years. Preceding today's panel, which will be moderated by my Brookings colleague, Louise Sheiner, I would like to introduce three speakers, who will offer opening remarks.

Leonard Schaeffer is the Judge Robert Maclay Widney chair, and professor, at the University of Southern California, and a trustee of both USC and the Brookings Institution. Mr. Schaeffer provides generous support to the USC-Brookings Schaeffer Initiative, which helps make the work we do possible. I'd like to reiterate Brookings' commitment to independence and underscore that the views expressed today are solely those of the speakers.

Richard Besser is the president and CEO of the Robert Wood Johnson Foundation. The foundation provides generous support to the USC-Brookings Schaeffer Initiative, which helps make the work we do possible. I'd like to reiterate Brookings' commitment to independence and underscore that the views expressed today are solely those of the speakers.

And Tsung-Mei-Cheng, or Mei, was Uwe Reinhardt's wife and lifelong colleague. She is the health policy research analyst at the Princeton School of Public and International Affairs. Louise, I'll turn it to you, oh, no, sorry, Leonard, it's for you.

MR. SCHAEFFER: Thank you, Paul. I'd like to join you in welcoming all of our friends to today's webinar. It's great to see so many people interested in exploring the issues around U.S. Health Care Prices.

As Paul mentioned, this webinar series is being conducted in honor of Uwe Reinhardt. I first met Uwe in 1979, when he asked me how someone with my limited academic background could be running the Federal Medicare and Medicaid Programs. I told him that I had graduated from Princeton before he began teaching there, so I had old fashion credentials, and besides, I could always ask him for help, which I did. Over the years, we became colleagues, and then close friends. As many in the Health Policy World know, Uwe was an outstanding economist, whose insights were always conveyed with wit, charm, and humanity.

As Paul mentioned, in 2003, Uwe co-authored a groundbreaking paper, published in Health Affairs, entitled, "It's the Prices, Stupid". The title was typical of Uwe. For those too young to remember, this was a play on the phrase, "It's the economy, stupid", that was used in Bill Clinton's presidential campaign. Uwe's influential paper used data from 30 OECV Countries, to show that the U.S. spends more on health care than any other industrialized nation. However, on most measures of health service use, the U.S. was actually below the OECV-Media. The evidence suggested that the difference in spending was due to higher prices in the U.S.

For Uwe, the most important question became what are Americans getting for their higher health care spending? Today, we are going to continue this -- the discussion on health care prices, by focusing on a review of the evidence used to compare prices, both within the U.S. and around the world. During this and subsequent webinars, I hope we can take inspiration from Uwe, who never wavered from the belief, that values and a vision for a better society must be part of any health care policy discussion. Before we begin, however, I should tell you that the idea for this webinar series grew out of a conversation with Mei Reinhardt, an old policy expert in her own right, and also a good friend.

I'm very pleased that Mei is going to join us today, and you'll hear from her in just a few minutes. Now, let me turn to -- turn it over to Rich Besser, president and CEO of the Robert Wood Johnson Foundation, who will give his perspective of Uwe's work on health care prices. Rich, you're on.

MR. BESSER: Thanks very much, Leonard, and thank you, Paul. I want to add my

welcome to the two of you, to everyone for joining us today. It's a pleasure to kick off the webinar series to honor Uwe Reinhardt in his work. I want to commend Brookings, and everyone who's participating in these talks, for making sure these important talks take place, and they couldn't be taking place at a more critical time. The COVID pandemic is shining a bright light on the inequities, the inefficiencies, and the injustices in our health care system.

The Robert Wood Johnson Foundation is really pleased to sponsor this series. Today's discussion is one of three that will be focusing on different policy approaches to make health care more affordable and widely available. There'll be a discussion, later this month, on whether the public sector needs to take a larger role in determining health care prices, and then, in October, the third part of the series, we'll take a look at the way other countries are addressing health care cost, and what we can learn from them.

Uwe was committed to finding better ways of making quality health care more affordable, more widely available to all, and he knew that it wasn't just an issue about constraining costs. It's also an issue about health equity because everyone in America deserves the right to have a fair and just opportunity for good health. It's a privilege to pay tribute to Uwe in this way.

I grew up in Princeton, and I've long been familiar with Uwe's legendary status as a scholar and a teacher. He was renowned for his amazing ability to communicate, about very complex subjects, in ways that were insightful, informative, sometimes funny, but were accessible to his audiences. He was a passionate advocate for a better and more equitable health care system, which he demonstrated in so many ways.

One example, I remember his work as chair of the New Jersey Commission on Rationalizing Health Care Resources, and this was back in 2007. He took tremendous pride in the work that he did with that commission, and he was instrumental in leading a successful effort that put a cap on what hospitals could charge people who were uninsured. Today's topic was central to Uwe's work. It's particularly relevant right now. The pandemic is showing that our health care system is in tatters, and constraining costs is a complex issue that's going to take a lot of creative thinking to come up with equitable solutions.

It's our hope that this conversation will contribute to that in important ways. So, I want to,

again, I want to thank you for being here, and for honoring Uwe in this special way. With that, I'd like to hand it off to Mei Cheng, for her remarks. Mei, you'll need to click on the little microphone button, in your lower left. There you go.

MS. CHENG: Okay, thank you so much, Rich. I want to give my special thanks to your and the Robert Wood Johnson Foundation, for your generous support to make this conference, and now webinar series, possible. I also want to thank you on behalf of Uwe, and Uwe and I had long wanted to do a conference, a National Conference on health -- on payment reform because our country really needs it, and so, I went to see you, and the conference was born, and you and the foundation really just turned what was an idea, and hope, and vision, of Uwe's and mine, into reality.

I would also like to thank Brookings, and specifically to the USC-Brookings Schaeffer Initiative for Health Policy, and its man in charge, Paul Ginsburg, for hosting and organizing this conference. Your work is responsible, why we're here today talking about this very important issue, and, Paul, you and Uwe had both served on the Congressional of Physician Payment Review Commission, for many years, and you were the Executive Director of that Commission, and so, I'd like to thank you very much, on behalf of Uwe.

So, now, can I go to my slides, please? I want to talk to you about Uwe's thinking on some of these issues. So, I go -- do I go to share screen? Is it not sharing?

MR. GINSBURG: It is sharing, Mei. You just have to go through the slides now.

MS. CHENG: Oh, now, I need to go to my slide, though. I don't see my slide here.

MR. GINSBURG: Move it to slide show.

MS. CHENG: Yes, okay. Do you now see the slide?

MR. GINSBURG: It's perfect.

MS. CHENG: Thank you so much. So, I'm going to talk about Uwe's thoughts on the role of government in determining health care prices, and a reform proposal that he had in mind for many years. I hear so well for those of you who haven't seen him, that he was born German, but left Germany (audio skip) when he was drafted because he was so angry at what the -- what Germany did, in World War II. So, from there he went to America, and from there he went to Princeton. Oh, you couldn't see the -- yeah, where he taught for close to 50 years, and I would like to dedicate my remarks today to Uwe.

So, the theme of this conference is about the public sector, whether issues play a larger role in determining health care prices, as the high cost of health care in America visits heavy financial burdens, on American families, pricing tens of millions of Americans out of needed care. At present, we have more than 30 million Americans who (audio skip). In the decades after the second World War, health policy advisors and health policy makers have argued inconclusively, arduously, over the question, Government versus Market, or Regulations versus Competition, but the empirical evidence on this issue has been inconclusive.

So, this debate has proceeded, and still does, mainly on etiology, and who holds political power, and not on evidence. So, health reform, therefore, meandered between market and government. Now, some years ago, it was in 2012, it was -- Uwe was -- Uwe and I wrote a paper for a book by the International Monetary Fund, on the perspectives of the appropriate role of the Private Sector in meeting health care needs, and so, we -- so, we talked about some of the things that I just mentioned, and our overarching conclusion of that long chapter was that a health system can enlist the power and ingenuity of the private sector, as long as the ladder is regulated and provided with incentives that would naturally lead it to stay within the moral norms, ethical norms, that society wishes the health system to serve it.

So, I already mentioned that I'd like to share Uwe's thoughts on the role of government, and his reform proposed for America. In this proposal, he believes that we'll both bend the costs, expanding growth curve and expand health insurance coverage, therefore transforming America to a high performing and sustainable health care system. Years of study, analyzing and working with the American Health Care System, in both government and the private sector, lead Uwe to conclude that a different approach to running our health care system would and could better and perhaps far better serve America and Americans.

So, Uwe's idea and proposal is this, an all-payer system for the United States, and I will just quickly walk you through what is an all-payer system. So, Uwe wrote a paper, which was published in Health Affairs, and that talked about the all-payer system, and he -- in the end, he concluded by proposing that. I propose that this price discriminatory system be replaced over time, by an all-payer system to -- as a means to better control costs, and ensure equitable payment, and so, Uwe talks about how providers are paid in an all-payer system. Now, under such a system, all the insurers of a state

would pay all the providers, in that state, the same price, for the same health service, with adjustments only for differences in the inputs -- in the price of inputs used by health care providers, as under the -- our Medicare scheme, and who sets prices, then, in all-payer systems? It can be set one of two ways.

One is the prices are negotiated on a regional or state basis, in Germany's case, between representatives of associations of providers and representatives of associations of payers, or prices can be set by an independent rate commission, both representative for -- of insurers and payers, as is in the case of Maryland, for hospitals, here, in the U.S.

Now, I will also quickly walk you through some of the strength of all-payer systems. First of all, it's -- it's -- they're equitable. All-payer system countries believe in social solidarity. So, they have health insurance for everyone, and cover everyone with the same benefits, and another strength, a big one, is a better control of overall health spending growth, and the health insurance is fully portable, not tied to your job. So, there's no problem with job lock, and everyone has free choice of insurers, and doctors and hospitals, and, of course, they have much, much lower administrative costs, in these all-payer systems.

And then, of course, there's a rampant price discrimination, as in the U.S., because every provider gets paid the same fees, once the negotiated fees are agreed upon, and there are no surprise medical bills, and this is really wonderful, they have better outcomes, people live longer and seemed healthier than Americans. Now, I'll show you some data on all-payer systems, and you can appreciate better what I was talking about. Now, National health spending as a percent of gross domestic product, in the U.S. and all-payer systems look at it for Germany, for the Netherlands, for Japan, and for Switzerland. On average, these all-payer systems spend roughly six -- two thirds of what we spend in this country, and yet we, as I mentioned, have no health insurance for everyone.

Next, is per capita spending. The row of red letters, U.S., per capita U.S. spending, this is the latest from OECD, is over \$10,000 -- \$10,500, and in Germany, Netherlands, and Switzerland, you can see they are all much lower. An OEC average is even lower, and in terms of growth, in health spending, in these countries. I put in some single payer systems, Taiwan, Canada and Denmark. You can see that growth has been very stable, and then Germany is quite stable, the Netherlands, stable, and it even actually went down. So, Switzerland is the only country where health spending was going up a bit

fast. But in the U.S., on the left -- on the left of this slide, you can see our growth -- first of all, our spending is much higher, and our growth also has been -- the growth slope has been far steeper.

Now, if you look at just U.S. and Germany, since I'm going to talk about the German all-payer system, that difference is really displayed in the graph here. Germany has a very, very stable National Health Expenditure over the 18 period -- 18 year period, from '92 to 2018, whereas the U.S., you can see it's uneven and much higher, and this is an interesting slide, it's the latest data available in the world, I would say, from the International Federation of Health Plans. I got these -- data in January, this year, and this one is completely interesting, in those medical prices, of OECD Countries and America.

The red dots, all the red dots, are U.S. prices. So, they all lined up on one side, 100 percent. You can see that for the other rich OECD Countries, the ones in Europe, prices are anywhere between 20 to 60 percent. They cluster in this range, lower than prices in the U.S., and take one drug for -- to demonstrate, Xarelto, which is a very widely used blood thinner. In America, the price is \$380.00 for a 30-day supply, but just look at the all-payer countries of Germany, Switzerland and Holland. Germany \$110, Switzerland \$80, and Holland is \$60. So, they are a fraction of our price. Now, of course, in America this was from Uwe's New Jersey Commission report. Uwe's show that these are the different price for the same procedures, that one California insurer paid to different hospitals. The prices vary for appendectomy, for example, from \$1,800, for hospital A, to as high as 13 -- more then \$13,000, for another hospital, and this is an -- interesting because you say all right, so they are cheaper to run, but what about their outcomes? So, we look at amenable mortality, which is mortality that can be prevented, avoided, with timely access to good health care.

The one line by itself, the dark red one, that is us, the United States, and the cluster of lines on the lower -- on the right side, these are the OECD -- the other OECD, the rich countries. Germany is that -- is that darker blue line there. So, Germany, in the same period, a minimum mortality declined buy close to 40 percent, but in America, even today, our amenable mortality is below the OECD medium, so we're doing worst then 50 percent of the OECD countries. So, I just want to say a word, this is an important point to mention about all-payer systems, and that is the role of government. So, what is role of government in Germany's all-payer system? It's a very important principle of self-governance, they call it, and what this means is that government role is limited to setting policy objectives, at the

Federal level, with implementation and enforcement left to the self-governing stakeholders, and they are self-governing associations of insurers, the call them Sickness Funds in Germany, and Associations of Provider Organizations, through the Federal Joint Commission, which oversees and defines uniform rules of operations, what benefits are covered, how health care is distributed, and they coordinate across sectors, and it also oversees quality and efficiency.

Germany has a very good Health Technology Assessment Organization, that makes coverage recommendations, and so, I point this out because I think this feature of the German System should appeal to Americans, given the intrinsic distrust, by many Americans, of the Government. So, I have recently wrote a paper on all-payer systems with a lot of the newest data, and in particular I cited Germany as an example, for lessons for us, and you can access it on the web, and then I just want to mention that many of the things that I mentioned, just now, are all in this book, Uwe's last book, "Priced Out: The Economic and Ethical Costs of American Health Care", it came out last year, 2019, and so, I end and leave you with Uwe's question, which he had asked again and again. Is it time for a more rational all-payer system for the United States? Thank you.

MR. GINSBURG: Thanks, Mei. Now, we'll turn to Louise Sheiner to moderate the panel.

MS. SCHEINER: Hi, thank you so much. I'm Lousie Sheiner, from Brookings, from the Hutchins Center on Fiscal and Monetary Policy, and I'm very pleased to be included in this event today. I worked with Uwe on the 2010 Medicare Technical Panel. I, of course, had heard of him, for many years before, but I didn't know him, and, you know, what an absolutely kind, nice man. His caring for other people, just shown through, and it was such a -- really a great pleasure for me to get to know him as a person, and, of course, to learn from him. So, I'm really tickled to be part of this.

Okay, so, let me tell what we're going to do today. We have four panelists, which I will introduce in a second. They're each going to show -- talk for seven to eight minutes-ish, and then we will have a discussion, and then open it up for questions. While you're watching the panelists, if you have questions or comments, you can send them, you can comment, even through Twitter, at #HealthcarePrices, or you can email to Events@Brookings.edu, and then we'll collect them all, and we'll see how many we get to.

So, let me first introduce all of our panelists, and then we'll open it up. So, our first

speaker is Daria Pelech. She is Principle Analyst of Health Retirement and Long-Term Analysis Division, at the Congressional Budget Office. Next, we have Melinda Buntin, who's the Mike Curb Professor and Chair of the Department of Health Policy at Vanderbilt University Medical Center. Then, we have Mike Chernew, who I also got to know on that Technical Panel, who is the Leonard D. Schaeffer Professor of Health Care Policy and Director of the Healthcare Markets and Regulations Lab, Department of Health Care Policy at Harvard Medical School. And, finally, we have Amitabh Chandra, the Ethel Zimmerman Wiener Professor of Public Policy and Director of Health Policy Research at the Harvard Kennedy School, and the Henry and Allison McCance Professor of Business Administration, at the Harvard Business School.

So, thank you all for being here. We will have one panelist go, and then you'll hand it off to the next. So, Daria, you'll hand it off to Melinda. So, Daria, then let's leave it to you, and you can share (audio skip). Thanks very much.

MS. PELECH: Thank you, Louise. Let's see how this slide sharing business works. All right, so, I have to start by disclaiming, and saying that these are my opinions, and not the opinions of either the Congressional Budget Office, or any of my colleagues there.

So, rather than -- going off pretty far already. Rather than asking whether prices are too high, or too low, I'd like to start by saying, what is a price suppose to do? So, one might say that prices are suppose to be signals, of how to allocate goods, and services in an economy. So, market-based prices should convey information. They should tell providers that -- they should the costs of providers supplying a good, and also consumers' willingness to pay for that good.

With this definition in mind, we can consider what we know about healthcare prices in the U.S., and whether we think they seem to be sending these full signals. So, the information that I find most informative is how private prices compare to those of public payers in the U.S. So, I'll start there, and here I will distinguish between commercial insurers, which are insurers who are operating in employer sponsored markets, or non-group individual markets, and then another type of private plan, sometimes offered by the state insurers, which are Medicare Advantage Plans, offered through the Medicare program, or Medicaid Plans -- Medicaid Managed Care Plans, offered through the Medicaid Program, and in commercial plans, specifically, so, those that are employer sponsored in the non-group

market.

We have a slide showing, just a lit review from the ACCI Institute, talking about what prices are, compared to Medicare on average, and you can see the in-patient and out-patient hospital prices are often two to three times what Medicare would pay for the same service, and physician prices are 20 to 30 percent higher. Of course, this slide is showing you variation across studies, but it's masking a range of variation across providers, services, insurers in geographic areas.

So, just to give you an example, in the -- excuse me -- the physician space, estimates suggest that general practitioners are only paid 10 to 30 percent more than Medicare, whereas specialists are paid 70 to 80 percent more, and sometimes much more. Advancing, there we go. The situation seems to be much different in these quasi-public plans, so the Medicare Advantage and Medicaid Managed Care. So, these are private plans offered through public programs, and in Medicare Advantage, specifically, private insurers, sometimes the same private insurers that are operated in commercial markets, generally seem (audio skip) roughly Medicare fee for service announced.

So, here, I'm showing you two slides, in short order. The first shows what commercial payers are paying for specific services, physician services in the U.S., and then the next slide is showing you what those same insurers are paying for the same services, in their Medicare Advantage Plans, and you can see that in Medicare, prices for the same services vary much less. In some cases, they appear not to vary at all, beyond the level that they vary in Medicare fee for service, and I think this comparison is really helpful because it highlights the role of bargaining, and how these prices are determined.

So, Medicare Advantage is special. In Medicare Advantage, patients can't be billed more than Medicare fee for service, for specific services when they go out of network. This limit on out of network billing may be giving insurers kind of a bargaining stake with providers, so they can say, be out of my network, I won't pay you more the Medicare fee for service, I will be a hassle when you try to bill me, and I will not steer patients your way, or you can be in my network, and I will pay you exactly Medicare fee for service still, but I will smooth the path of billing, and I will steer patients towards you.

You see a hint of this bargaining power when you compare the red dots to the blue dots. So, red dots are out-of-network prices, and blue dots are in-network price, and you see that for commercial plans, they're much higher for the red dots than the blue dots, and then in Medicare

Advantage they're exactly the same, and this doesn't tell that private prices are too high, or too low, it just tells us that when insurers can bargain with providers, they will, and they can extract lower prices.

I'll talk about another situation, in which, bargaining power can introduce -- can influence prices in strange ways. So, there are specific services that we would call non-shoppable, and these are emergency services, ambulance services, or ancillary providers operating in hospitals, such as anesthesiologists, pathologists, and neonatologists, et cetera, and I think that the situation that I'm talking about is well documented in the media, and kind of the NPR Bill of the Month sort of things. What happens is that, for instance, a woman goes to an in-network hospital, with an in-network OBGYN, to give birth, and then her baby is visited by an out of network neonatologist, and she has not had the chance to approve this service in advance, or shop across providers. Sometimes, she is charged -- sometimes that neonatologist is out of network, and sometimes she is charged much more than she would have been, had they been in-network, and in some cases her insurer does not pay.

These cases are very consequential to individual consumers, but as a part of the overall healthcare spending pie, they don't matter that much because they're rare. But what I think is interesting is what they do to in-network prices. So, this slide, it's, again, from HCCI, showing in-network prices relative to Medicare for anesthesiology, and what you can see is that, even in-network prices, these provider types are being paid much more than similar provider types, similarly educated providers might be paid for similar services. They're being paid, you know, up to seven times what Medicare would pay, and there is some evidence that these prices are rising over time.

There's some evidence about how prices vary across areas, and I'll go through that very quickly because I think other people will talk about it as well, but the literature on variation in prices shows that prices vary, somewhat randomly, maybe we don't know why, it's hard to know why a knee replacement in Dallas is \$40,000, and in Cambridge, Mass., it's \$28,000. But, here, I think that one thing you can do, is, again, compare to Medicare fee for service prices, which are adjusted for some range of inputs, and you can see that providers are paying -- I'll skip to my next slide. Providers are paying -- being paid, you know, sometimes two-fold variation, within the same metro-area and within the same state.

Prices can vary for a lot of reasons, and variation alone does not suggest that they are --

price are too high, or too low, or anything else. I think that one thing that is troubling is that bargaining power has appeared as a consistent factor, influencing prices across and within geographic areas. Provider bargaining power, as measured by traditional measures, such as market share, or less traditional measures, such as, you know, hospital system membership or vertical integration, have been found to be correlated with higher prices, for both hospitals and physician services. Conversely, insurer market powers seems to reduce those prices, though I will caution, those two things are not independent. Insurers are less likely to enter markets where providers already have market power.

So, to sum up, private insurers pay healthcare providers substantially more in private plans than in public programs in the U.S., but only in some of their plans, particularly in commercial plans, less so in the quasi-private Medicare Advantage and Medicaid Managed Care Plans. In those plans, they seem to be able to use their leverage, the leverage of public payers and restrictions on billing to drive down prices. I don't think this tells us if private prices are too high or too low. These are normative questions, but one can return to the idea that prices should be sending useful signals, and when they are influenced by bargaining power, whether it's driven by market, market shares, or by the consumer inability to shop, one might worry that they are sending signals that are less useful than economists would desire. I'll hand over to Melinda, here.

MS. BUNTIN: Okay, thank you so much, Daria, and I'm absolutely delighted to be here. I know that this is going to be a very lively panel, given the participants, and I will get started.

So, I wanted to start by answering the question that was posed by the title of this event, are healthcare prices too high, too low, or a mix of the two, and I would argue that healthcare prices are, on average, too high, but that prices vary so much, in fact, as Daria was just telling you, and as Mei alluded to as well, they vary so much, by service and by payer, that the answer, at that level, has to be a mix of the two. It has to be that answer, at anything other than the highest level, the 10,000-foot level, if you will, which perhaps where this skydiver is.

And, in fact, there are some services that are going to be undervalued, rel -- underpriced, relative to the value they convey, and I know you're going to hear about that from another speaker.

MS. SCHEINER: Melinda, are you on slide show?

MS. BUNTIN: I believe I am.

MS. SCHEINER: Okay, I'm seeing both, but that's okay, go ahead, sorry.

MS. BUNTIN: Can maybe, Paul, can you give me a thumbs up if you can see my slides?

MR. GINSBURG: I can see them, but not -- they're not filling the screen. I see parts of two slides.

MS. SCHEINER: Melinda, go ahead and click, (overtalking).

MR. GINSBURG: I can see the slide coming.

MS. BUNTIN: Okay.

MS. SCHEINER: Good.

MS. BUNTIN: Great. All right, I'll just do -- play from current slide. Is this better? Same thing?

MS. SCHEINER: It was better before you just hit that play from current slide, at least it was just one slide. Yeah, that's fine.

MS. BUNTIN: Is that good, now?

MS. SCHEINER: Yes.

MS. BUNTIN: Yes? Oh, okay, thank you. So, all right, so, all that said, I'm going to do something that economists love to do and that Professor Reinhardt, and because I was Princeton Undergrad, I can -- I will always think of him as Professor Reinhardt, always did to great effect, which is to reframe the question.

So, Professor Reinhardt always reminded us that one person's cost is another person's income. He said that frequently, and for that reason, I think it's almost impossible to talk about reducing prices in absolute terms. What we can do, though, is that we can either reduce the rate of increase in prices, which people refer to as bending the cost curve, or we can change the terms of payment, and I would include in that moving towards value based payment, and I would also argue that, really, we should, at that 10,000-foot level, again, care more about per capita spending than prices per se because prices and utilization are linked, hence the reference here to price times quantity, or P times Q, and arguably what we should be caring about is spending, and whether we're getting from our spending what we hope for, in terms of value and health outcome. And I'd also argue that this slide shows that there's something that we've been doing, over the past 20-30 years, that is bringing down this growth in per

capita healthcare spending.

So, the yellow line shows that the average growth and per capita healthcare costs, in the '90s, was around six or seven percent. It declined a little bit, in the '00s, and then really since 2010, or even a little earlier, has been much lower, and so, we've seen this decline in rates of growth in per capita costs, and that's tied in part to prices, but effects utilization and the development, and is -- but is effected by utilization and the development of new technologies, as well, and, of course, all these things are tied together.

I'll led -- I'll leave it to Amitabh, to get into the details of this, but, of course, the price effects the utilization, and the price you expect to be paid affects your desire to develop any new technology or service that you might offer in the Healthcare Market Place. And I'd like to look at the annual articles, published in Health Affairs, about the National Health Expenditures, and I made this slide, obviously, for those of you who are in the field, for an article that -- it got published in Health Affairs, this past fall, and the slide shows the titles of those articles that the CMS Actuaries have written over the past decade, roughly.

And what's notable is that they mention reasons for rising costs, including spending for -- to cover more people, through the Affordable Care Act, or for prescription drugs, and they tie growth in spending to the economy, but they don't mention prices, really, until we get 2018. So, I will say that I think some of the other speakers will comment on what's been going on lately in the health Care Market, in terms of competition and negotiating power, as Daria has also said, has already said.

But, really, throughout most of the past decade, we've been looking at rises in prices -- I'm sorry, rises in spending, that we're really tied to increases in coverage, or prices being paid for new pharmaceuticals. So, how has that happened? Well, in fact, in the case of Medicare, which Daria was using as a reference, right? She was talking about other payers were relative to Medicare. There have been direct effects of policy that have held down the rate of increase and spending, and here are just a few of them. I won't read them, but you can see them on the slide. There have really have been reductions in technical things, like market basket increases, or adjustments for productivity, or changes to Medicare Advantage payment rates, to reflect changes in coding, and all of these have had the net result, that they've held down spending by at least five percent, over this period, over this eight year period, and

again, arguably more, because of this interaction between prices, utilization, and the development of new technology.

So, where does this leave us? It leaves us actually thinking that public sector prices are fairly stable. Policy restraint maybe working, at least in the public sector, and really a question might be, can the private sector hold the line on price increases, and with that, I will turn it over to my colleague, Mike Chernew.

MS. SCHEINER: Mike, you're muted.

MR. CHERNEW: -- and yet, so yes, I was muted in saying thank you to Melinda and Daria. I have to add thank you to RWJ and Brookings. It is wonderful to see you here, Mei. I miss seeing you, and I miss seeing Uwe quite a lot, having him not around reminds me how much I miss his humor, and so, I apologize to everyone on the webinar that I am not as entertaining as Uwe.

I want to pick up on a lot of the themes that were made before talking more broadly about the economics of what too high means. I think, I'm going to show my slide show. There we go, that should probably be better.

So, let me start with a place that Melinda said. First of all, I'm going to focus on whether commercials of prices are too high, and I want to start with what Melinda said, which is there's wide heterogeneity in prices. So, the -- this is an example of what Mei showed -- I mean Daria showed, variations in markets, I won't show that, it's very similar to what Daria showed you. There's a lot of variation across the averages in markets, but there's wide variation within market, and this is almost exactly what Mei showed you with different slides. The U.S. prices are pretty much higher than everywhere else, so, it wouldn't be that novel to say, at least for international comparison, it does seem to be the Price is Stupid.

This level of heterogeneity means that the question can't be, are prices too high, there's too much heterogeneity. It has to be something like, are we buying a meaningful share of healthcare at a price that is too high, right, you know, and just so you know, often the highest priced providers have the biggest share of the United States, for a range of reasons. Of course, part of the reason they have high prices, is because they have market power. So, sometimes, market share and prices actually go positively together, at least in a descriptive sense. So, the question then becomes what is the right metric

for knowing whether these prices that are being charged by some providers is too high?

So, let me run through a few basic framework ideas, that we can come back to later in the question and answers. The first one is, as is common, to compare commercial prices to Medicare prices, as Daria and everybody else does, so, that would give you, for example, ratios of Medic -- commercial to Medicare. The problem there, of course, is you don't know from that, if the commercial prices are too high, or if the Medicare prices are too low. So, people argue one way or another. I'm not particularly a fan of that metric.

Another is relative to cost. There are prices, prices high relative to cost of production. I'm not a fan of that metric, in part, because costs themselves are influenced by prices. If you pay more, costs will rise, if you pay less, costs will go down, and of course, we can't measure quality very well. So, there's a quality moving around, as well, in that. That being said, if you were to measure prices relative to costs, despite my dislike of that approach, you would find that by and large commercial prices are higher than marginal and higher than average costs, to the extent that we can measure at least for facilities.

This is much harder to do for professionals because the costs are harder to figure out because of the cost of education and things like that. The next metric that is commonly used, which relates to a little bit what Mei was saying, is whether we're getting the quality for what we pay. So, as prices high relative to the quality, that's complicated because quality is hard to measure. It is tempting, as an economist, to use some sort of revealed preference argument to say, if people are buying it, it must be worth it.

It's like an old joke about The University of Chicago economist who sees a \$20 bill on the ground, then tells his friend to pick it up. Friend says, it can't be there because someone would have picked it up already. The world's always efficient that way, and the revealed preference arguments kind of have that flavor, and, again, because quality is an unobserved, it's very, very hard to refute that. So, I'd like to make a point in that regard.

The first one is, I'll call it broadly the monopoly experience. Even in a monopoly case, where people are buying the monopoly product, the price is considered too high because it's above marginal costs, it's distorting behavior. So, if there's a market failure, the fact that somebody was willing to pay for something doesn't mean that that is an efficient price in an economic sense, and in healthcare,

there are so many market failures that it's hard to argue that we're getting the appropriate price, in a revealed preference kind of way. Much more likely in my opinion, you are seeing a lot of market failures. I'll say more about that in a minute, but before I do, I want add one other wrinkle.

There is a growing body of literature coming out of, basically, the behavioral economics framework, that shows that people just don't make good choices even when they're faced with the prices. There's a paper by Jason Oblique and John Gruber, in part D. There's a paper by Anna Senenko and Rich Hirst about health plan choices, but there's a lot of examples about of people choosing products, when there is a dominated or clearly better product, and they don't switch, and, again, we can debate what to make of that literature, but I think it's increasingly hard to argue that peoples choices are so well-informed that we believe the market is generating some sort of economically efficient price.

So, a few other things to illustrate this point. The first one has to do with mergers. We know that mergers cause prices to be high, that was mentioned before, and I think it was Daria's talk, but this is some work on hospital mergers and quality by some colleagues of mine, Nancy Bolliers (phonetic), the lead author, and it shows the change -- I like the upper left hand one the best, which is patient experience because that's probably the broadest measure of quality. It went down after mergers. The clinical process measures were kind of an upper trajectory, and kind of stayed a little bit higher, but things like readmission rates and mortality were certainly not better, post-merger. So, while it is hard to measure quality, we know mergers increase prices, and as near as we can tell, they don't improve quality. There's another way of going at this, which is to ask, well, what happens if you give people the actual incentives? What do they do, that shows what they might actually want to buy, if they had to pay? So, this is work from Jamie Robinson and Tim Brown, on reference pricing, and it's in California, where CalPERS was there, but you see is, when people had to pay the added costs, you go to the high-priced places, they left in droves. So, the fact that so many people without records prices were actually going to those places was not an indicative that they really were willing to pay. It was indicative of the insurance system, it was shielding them from the prices, and when that shield went away, they went in droves.

I might add two other things about this study. One is that prices, or the high-priced places, actually came down after this, suggesting that these type of models increase competition and there were several studies that found no differences in quality, admittedly hard to measure, by looking at

things like complication rates, for example, after surgeries. They didn't find a big difference.

So, it seems the people are willing to, you know, reference pricing since moved somewhere else. This was from a study we did on tier networks, which is similar but broader, and, again, when employers switched people to tiered network products, they moved from the non-preferred to the preferred hospital, suggesting at least some people, not all people, but at least some people are paying -- are going to places for care when they simply don't value that care at the extra price, and when they're forced to pay the price, they shift to much -- much lower priced providers. You see the same on the exchanges. As soon as people have to pay for insurance, all of a sudden the exchanges had very narrow networks, suggesting that if you were going to make the revealed preference argument, it would -- preference that I think is being revealed is largely a preference away from some of these high-priced providers, and I think many of the reasons why you see high-priced providers is because the market isn't working particularly well.

A few other points. The first one is high prices alone isn't necessarily what economists would consider a problem. Some of that is a transfer from consumers to providers. The real concern would be whether or not there's a distortion in people's behavior. So, I want to emphasize two distortions. One of them is as prices go up and premiums follow, you'll see higher cost sharing, which puts more risk on people, distorts behavior in that way. You'll see less coverage, people dropping coverage in a whole of ways, and because that brings the public system into the healthcare space you end up with a whole series of tax distortions because of the way we're financing things publicly. So, we really need to think about the distortion that the high prices are causing.

My last set of points relates to policy choices, and I'm not going to talk about them at great length, although I'd love to do that in the question session. So, first, let me start with what I believe. I believe that some prices are too high. The question is what to do. One thing to do is to work on improving a whole series of institutions to promote competition and get lower prices. Paul has a paper. He's written on a bunch of things to do. I want to talk more, but that includes antitrust, but there's a bunch of other things, like banning anticompetitive actions and some pro-shopping type interventions to get people to search.

My personal view is while I support all those things that they are going to take too long

and have a limited impact, until we figure out how to do them better, and so, the next choice becomes what to do if you want to regulate prices directly. My personal view is that we have to decide what form of regulation should take, how strong it should be. I like the idea of nibbling from the top. So, as I said at the beginning, some prices are too high. We could talk a lot about competition. Why don't we just go after the super high prices. Certainly, in the surprise billing case, I think you can argue that those prices are too high. Why don't we just address surprise billings to start?

There's other stronger ways. People talk about the public option as one way to promote competition and keep prices down. That's true. I think there's a lot of challenges in doing that, but that is for people at a higher pay grade than me. So, with that, I am now going to turn it over to Amitabh.

MR. CHANDRA: So, this is my favorite -- this is my favorite Uwe Reinhardt quote, and I have so many of them, but this is one that I love to use, which is he -- he often described himself as a skunk at the garden party, where everybody was having a pretty good time, and the Uwe would show up and say a couple of things that would upset everybody. So, I'm not going to try to play Uwe, but I am going to try to say a couple of things that might be different than what you heard.

The thrust of my comments is that looking at price variation should actually make us curious about understanding why is there price variation, as opposed to saying because there's price variation, we need to regulate the prices. I think we need to think about the underlying reason for the price variation, and then think about different public policies, maybe it's competition, maybe it's narrow networks, maybe it's reference pricing, maybe it's removing the exclusion for health insurance that's provided by employers.

So, there's a lot of fascination for graphs of the type that you saw before. So, there's a lot of fascination for these kinds of graphs. Like, oh my gosh, prices are just so high in America. Like, a cesarean is a cesarean and, like, those guys in South Africa are paying like 25 percent of what we're paying, and if it comes to cardiac cath, like, you know, the Emirati cardiac cath, how can it be like 22 percent. Oh, maybe it's quality, but it just can't be quality because, like, a cath is a cath, and maybe if it's like 10 percent better, you know, this must reflect either choice inconsistencies, Americans are kind of uniquely stupid, Emirates are not, or it reflects, you know, this kind of view that prices are just this random phenomenon that can kind of be -- you can just kind of do -- they're playing with house money in some

sense, and so you can dupe employers or employees by kind of charging whatever you want, and there's this sort of thinking of explanations, where people will say quality matters, but it's really not enough, right, and I think that's incredibly lazy. I think that -- let's just start with the CT -- with the MRI.

Right, the MRI scan, which is over here, at the bottom, you can see in the second panel, very low for Holland, you know, it's much higher for New Zealand, but like let's just go through some examples for why it might be higher in New Zealand than in Holland. Maybe in New Zealand you get a 3 Teslascan, and in Holland you get a 2 Teslascan. Why do we think that that resolution should not affect the price? Was it an MRI, an open MRI, or a closed MRI? People are willing to spend a lot more money for an open MRI. Was the MRI done in patients who really needed the MRI? If I use the MRI very sparingly, I could charge a much higher price because I'm doing it in the high value patients. What is the quality of the doctor who is reading the MRI? An MRI done at an expensive academic medical center in Boston will be read by a very different radiologist than an MRI that is done in a community hospital in Boston. Why should those differences somehow not be important, given that we never measured that? They're not in our data sets.

So, it's easy to say trust me, I don't know if they are large enough, but there's something going on in the marketplace that, to me, it says maybe they are large. Now, it could still be the case that the extra price was not worth it. Maybe we don't need a 4 Tesla MRI, but that's quite different than saying it couldn't have been the 4 Tesla versus the 3 Tesla MRI.

Let's talk a little bit about another example. Let's look at cesarean differences. That's very popular, right, to look at C-section differences. So, in this graph, again, you see, like, South Africa, much lower prices toward cesareans, and then you've got other countries, like the Emirates, and Holland, and even the U.K., with much lower prices than the U.S. Why would that be? A cesarean is a cesarean. And I think you'll see a similar thing in the graph that Mike showed. Like, look at the price difference for cesareans in Los Angeles versus San Francisco. Like, how can that be? Like, it just can't be quality. Like, we're har -- we have a hard time believing that, like, San Francisco quality can justify, especially for that high-priced San Francisco provider, is enough. That's kind of the -- that's kind of the -- what I've been hearing, but let's think about cesareans.

You know, in the cross-country differences, was the patient given a room in a ward, or

was the patient given a private room or a semi-private room? The typical NHS hospital has a ward with 24 patients in it. The -- that product does not exist in America. Why do we think that the absence of a ward or the presence of a ward would not affect prices for cesarean in a first-order kind of way?

In the context of the price variation within a city, like let's just look at San Francisco, why was -- could it be the case that the patient delivering at the expensive, high-priced cesarean hospital, was there a neonatologist or an anesthesiologist available, on staff, 24 hours a day? Did this hospital have a level 3 NICU? Did it have a level 4 NICU? Did the other hospital just have a level 1 NICU? What was the skill of the delivering obstetrician? Were they Board Certified? Were they Double Board Certified? Was the cesarean done appropriately?

Now, look at the difference between Los Angeles and San Francisco and the average prices. That was really striking to me, right, big difference, hard to kind of imagine. So, it's very easy to say this is randomness. This is just choice failure. But here's a fact. I've studied cesareans a lot. Cesareans are interesting because Los Angeles has an average C-section rate of about 34 percent. So, 34 percent of moms giving a first -- delivering the first time will have a cesarean. In San -- in San Francisco, that number is 20 percent, 20 percent versus 34 percent in the quantity of cesareans.

So, if we're doing a bunch of unnecessary cesareans in Los Angeles, but we're doing high value cesareans in San Francisco, would that not be captured in this price? And so, I think simply saying, well, we just think that's not important, trust us, it's being really, really confident in my ability as a consumer to trust a PhD economist who hasn't studied these things because they're not in our data sets. These things are not in the data. So, you have to like really get out there and measure that.

Now, it could be that when we measure them it could be the case that we find that the spending was not worth it, or the prices weren't worth it, but we would never know that if we said let's start to use a regulatory hammer because \$40,000 for a cesarean, that's just this idea that it's bargaining power, without thinking that the bargaining power of that hospital might reflect some very costly investments in quality, endogenous quality, by this hospital. Those endogenous quality investments may not be socially valued. Maybe Medicare ought not to pay for them. Maybe Medicaid ought not to pay for them. But someone, somewhere, is willing to pay for them, and so, we should be thinking much more about what would happen to patient welfare if we got rid of that \$40,000 price, after measuring what we

get for the \$40,000. Louise, how much time do I have? I just have one other point to make, but if I'm out of time, I can stop.

MS. SHEINER: You have another minute.

MR. CHANDRA: Oh, awesome. So, the last graph that I wanted to talk about was Melendez, which I like very much because I do think the ACA did a lot to reduce the slowdown in prices, precisely because of its ability or willingness to cut Medicare prices, which I think are too high because of the weird way Medicare prices work. So, I have no dispute with this graph, or its interpretation.

I think what I worry about, though, is continuing this practice of thinking that we can just sort of -- you know, if you put the right PhD economist behind the dial, they can turn the dial just so, and get the prices, the quantity, and the quality just right. I think that this view has two limitations. This process of the PhD economist turning the dial is very quickly captured by provider groups. We know how physicians determine their relative fees. There's a lot of work on this. Hospitals have lobbied Congress for lots of ad hoc additional payments. So, I think the more we start to rely on price regulation by Congress, while it can do some good, I think we also embolden and make larger the business case for lobbying.

Second, it requires the government to know -- to know prices, and this is very hard without an external benchmark, and so, the worry is that, you know, as government share in healthcare becomes larger and larger, very quickly the prices that start to be offered by Medicare and Medicaid start to look like monopsonistic prices. So, these are prices that are too low, and we would never know that they were too low if there wasn't a commercial market to benchmark these against.

I am not saying that we're in a world where Medicaid and Medicare are paying monopsonistic prices. It's actually hard to know that. Now, we have no view that, like, gee, maybe when we're doing these comparisons between Medicare and commercial, the quest (audio skip).

MS. SHEINER: I don't know if Amitabh had problems or I froze, but one of us froze. Can everybody hear me? Yeah? Okay, great. So, oh, we -- did we lose Amitabh? Okay. Good, it was not me. Well, so, I think he was almost done. I'll let him come back in on the discussion because obviously there was a lot of view just now expressed that were quite at odds in many, many ways. So, I think we're going to go back, now, and like broaden up each point up to everybody. I -- before I go on, I'm going to

remind everybody if you have questions you can submit them through Twitter, at #healthcareprices, all one word, or send an email to events@Brookings.edu.

Okay, let's step back and let's start right with Daria's slides and this whole question of comparing Medicare and commercial, and, you know, what's interesting, Amitabh, you actually just came back with kind of what my question was, is, so, Daria, you sort of made the point that these -- that if bargaining power has -- sets prices, then we're losing the price signal. On the other hand, I might say, well, that's supply and demand, and if there aren't enough people doing hip replacements in a city and the price goes up, that actually is exactly the signal that we, as economists, usually think about. So, so, how is -- so, tell me a little bit more about how you interpret this relationship between commercial and Medicare in this context, and then I want to see, you know, I want to open that question up to other people, too, because I'm sure everybody's looked at these commercial -- I mean, Mike, you already put your two cents in, how you don't think it's useful, and I also want to ask about, at the same time, you know, that interrelationship, like could Medicare prices provide the quality that they provide, if not for the higher commercial prices, maybe funding. Woops. Oh --

MR. CHANDRA: Is that a question for me, Louise, or is that a question for Daria?

MS. SHEINER: That one, no. I'm going to start with Daria, and somehow -- can you stop sharing your screen --

MR. CHANDRA: Yeah.

MS. SHEINER: -- and then maybe we'll --

MR. CHANDRA: Yeah.

MS. SHEINER: Okay, great. Daria, why don't you start with that, just this idea of no signal?

MS. PELECH: I think there are a lot of questions embedded in what you just asked. I think that one of the first things to highlight is that I'm not saying that Medicare prices are right, or that commercial prices are right, but the comparison is useful, and it would highlight some surfaces where commercial insurers are paying less than what Medicare pays, and sometimes they have the services you might want to provide. I think Melinda was making a point.

So, some research shows that Medicare fee for service pays more for mental healthcare

than private payers do, in either their commercial or their Medicare Advantage plans. That goes back to this idea that there's something to be gained from bargaining, where maybe insurers don't want providers of mental healthcare in their plans, in their networks, because they don't want those patients. So, I think that there's these situations where you can see -- where you can see the interplay between insurers and providers having more to do with those prices than what a consumer might want. Mike said, and I think this was really important, he said, well, you know, on some level, people are paying for it, so, doesn't that mean that they want it?

I just came across this poll from -- it's from Westat and Gallup, where they say -- they found, pre-pandemic, that 77 percent of people think that they are paying too much for their healthcare, relative to their quality. That doesn't tell us what they should pay. It tells us that they think that maybe the prices have stopped sending them the signals of what -- of what value is.

MS. SHEINER: Melinda, you ended your slides with while Medicare's been able to keep spending under control, maybe the private sector now can, so, can follow suit, as if, again, as if the Medicare example is the good example, and therefore, you know, and so, how do you think about that? How do we know?

MS. BUNTIN: Well, I would certainly say, and I think I did say this, that when -- we can talk about prices on average, or we can talk about specific prices, and if we're talking about prices on average, then they may be high, relative to the value we're getting, but specific prices could be either too high or too low, and I'm certain that that is the case within Medicare, and we could probably all sit here and think of services that we think are too -- valued too highly or too low, on the Medicare fee schedule.

That said, there are mechanisms for dealing with that, and they don't just involve PhD economists. They involve lots of bargaining and evidence presentations by medical societies and the like, and we can discuss whether we think that process works, but it's probably a lot better than just letting prices be determined solely by market and market power because I don't think there are very many prices, at all, that are determined by consumer demand.

MS. SHEINER: Mike, can you tell me a little bit more about what message we should get from the variation within cities on prices. I mean, I think may -- you know, maybe Amitabh was saying this, too. If I looked at legal services and prices within a city, or architects, or many things, I would

perhaps see that kind of variation at -- what do you make of that? Like, why was that an important component of this discussion?

MR. CHERNEW: So, a few things. I think that the variation in prices, with -- in the magnitude of the variation in prices, suggests there's some aspect of variation in quality. Whatever that is, it's hard to measure, variation demand, in some aspect, a variation in market power. It's very hard to know which part is which and what to do about either. It does seem that if you allow people to face the actual prices, they move pretty quickly to the lower ones, suggesting to me that a lot of what's happening at the higher end is in fact people are shielded from the higher prices. They have an out of pocket max. They have a broad network. They're only paying a copay. There's market consolidation, and so, the geographic variation means they'd have to drive too far to get somewhere. So, some of the providers have monopoly power. That's what I think is going on.

I think what it means, in terms of policy, is you basically have to decide between two imperfect systems. One of them is some system where you have policymakers with support trying to figure out what to do to make the system a little bit more efficient, and the other approach is to try and figure out what to do to make, in some sense, competition work better and go after the market power.

My personal view is both of those are going to be imperfect and you should kind of do both at the same time, and on the public regulatory side, you have to recognize there's a lot of deleterious consequences of these market failures, in a whole slew of ways, and I think in the cost benefit of regulation is worth going after, and I'm using Amitabh's slide, the \$40,000 C-section, and see what happens before you argue, you know, maybe it's better, let's not go after them and see five, six other things. That's really -- really, the question is do you try a few things before you go after the problem, or you could go up to the problem weekly and then slowly see if you can get to some place where you think Welfare seems remotely better.

MS. SHEINER: So, I think that you -- we've just kind of talked a little bit about sort of this P versus Q but not a lot, and I'd kind of like to talk about it some more. So, Melinda, you said healthcare is P times Q, right? So, that's how we think spending is, how much you pay versus a quantity, and then the question is what, a quantity of what, you know, what -- I mean, Amitabh would say a C-section is not the same thing. You don't want to put -- you know, you might say the price is really high for some people,

and the price is low, but maybe that's a different quantity or different quality, and -- the same way, and one of the things I think is really an important question to ask, and we'll get back to, to Mike, your sort of -- your sort of big point, I think, at the end, but one of the reasons is, you know, the consequences of going and regulating prices will kind of depend on why prices are so high, potentially.

So, one question I think I always have is that we have really high prices here, is it I think three possibilities, probably some combination. One, we pay people better, and you said, Melinda, someone's -- who has crosses someone's income. So, that's the political consequences, but it's also, you know, good, middle-class jobs that we see for the future, maybe in the health sector, and if that means we're paying people well and therefore our prices are higher, that's a different implication than we're not paying people all that well, but we're just wasting so many resources.

We're, like, doing all these tests and buying the Teslas, maybe, and all this stuff that actually uses up real resources but doesn't buy us anything, so, it makes us poorer as a society, or it's this thing where it's not -- it's, and Amitabh says, it's amenities. You're not going to find it if you go control for mortality or something, but, you know, we spend a lot of money on all kinds of things, and it's amenities, and people are happy to have them, and aren't going to be happy if you shut them down, and so, of those three, I'm going to go around, when you say our prices are higher, you know, which do you think is really responsible for these high prices? Let's start with you, Amitabh.

MR. CHANDRA: I think a lot of this is amenities or measures of quality that are not clinical in the sense of -- I would not be surprised if, for example, in my example of, like, a variation across San Francisco hospitals, Louise. I would be surprised if the first order thing is it's going to show up in 28 neonatal mortality. I'd be very surprised. It probably shows up in the form of either better rooms, bigger rooms, better food, right, and hospitals compete on that, and patients respond to that. Now, as Mike said, maybe we make -- maybe we subsidized them too much, and I'm all for removing subsidies on things that are being subsidized by the taxpayer.

The other explanation, it could be that some of this is actual value to the patient in the form of insurance value. So, so, I feel better because I'm going to a hospital where there's a Double Board-Certified Neonatologist because I'm worried about the one percent chance that I might need her. So, I go there. Now, a bunch of us could say that wasn't worth it, but, like, to this patient, it was worth it.

It's an exotic preference, not clear to me that a social insurance program needs to take that into account, but if commercial insurers, if people in the commercial market, want to go there, and this is why I'm point -
- Mike's point about choice and competition is important.

If people have choices and they choose the \$40,000 hospital, I don't have a problem. If they have no choices and they have to go to the \$40,000 facility, I don't conclude markets are working. So, it really comes down to do they have a lower choice, and in all of Mike's graphs, there's tons of price variation. They've got tons of choice. So, either these places are the same, and they're choosing the \$40,000 place because of amenities, or they're not the same, and then we shouldn't be putting up price variation graphs.

MS. SHEINER: Mike? Yours.

MR. CHERNEW: Well, so, first of all, to answer your direct question, I think by and large it's market failure that's generated non-price competition, and so, you get a bunch of competition on amenities, and if we add people to insurance plans where they could have narrower networks or reference pricing, they would move away from all of those things, and in the fact that there's five hospitals in Boston, it doesn't mean that we're choosing the \$40 -- that anyone's choosing the \$40,000 one over the whatever, the \$30,000 one, because of the way insurance shields people, and the market failures are not just in the hospital side, of course.

There's limited insurer competition, and, frankly, I think employers have done a horrible job. I say that as the chairman of the Harvard Meds Committee. I've done a horrible job of giving people the sort of right incentives to make choice. We can discuss why. Maybe that has to do with the tax exclusion. That's another broader point. But I think, to answer your question about what's going on, I think overwhelmingly is market failure, and I think, and almost every example I'm aware of, when allowed, when forced to pay the marginal price of the \$40,000 C-section, very few people do, and in that -- combined with a whole bunch of choice behavioral economics things, where some of the people who do didn't realize that's what they were doing. Certainly, if you look at the people who get surprise bills, you're going to argue something's going on there that's not, oh, yeah, I really wanted a surprise bill.

MS. SHEINER: And do you think that that market failure that shows up, I think that's what you're saying, both adds sort of higher profits and higher wages, but also more stuff being done?

MR. CHERNEW: Yes.

MS. SHEINER: Oh. Yeah. Melinda, do you have a --?

MR. CHANDRA: So, that is a hard point. That last point is where I disagree with Mike. It's hard to argue that a monopolist both charges high prices and overprovides the care. That's just weird. Like, the monopolist is probably under-providing. If you think it's market power, we've got too little healthcare in America, in the commercial population, too little, too few cesareans, too few MRIs, too few stents, if you think that people are picking, yeah, providers with market power.

MS. SHEINER: I mean, what do you think about the possibility that some people have too much care, and some people don't have enough care because the price is such a impediment?

MR. CHANDRA: Yeah, at a macro level, absolutely, because we've never really, as a country, grappled with, you know, whom to cover versus what to cover, totally agree, but certainly for a patient like me, you know, if the argument is that poor Amitabh is to go to these high-priced providers who have all this monopoly power, what does that mean? I mean, it means that I get too little care, relative to marginal cost pricing.

So, if we reduce the pricing, I ought to get more care and it ought to be good for me, and I don't think that we're willing to say that. I think most people would say, my gosh, there is like -- he's getting, you know, he's getting a cesarean, or he -- I -- he's -- he, Amitabh, probably not getting a cesarean, but, you know, he's probably getting an MRI a little too frequently.

MS. BUNTIN: So, I guess, I don't mean to jump in. There are so many questions on the table right now, it's hard to know where to come on, but I would say just a few things. One, you know, you asked about P times Q. So, I'll start with that. I mean, I think Amitabh's argument would be an L.A. versus San Francisco, that P times Q might be the same because the prices are higher in San Francisco, but the rates of use are much lower. I don't know if that's true. That's a testable hypothesis. It'd be interesting to do that work, but time after time, in healthcare, we get into the situation where high prices lead or are associated with, let's put it that way, greater supply in things, and so, you know, if you changed up that marginal price for that high-priced hospital in San Francisco, would their C-section rate remain the same? We don't know. It could go down.

But we also have a situation where we don't have exactly monopolies, but we have a

conglomerate -- hospitals are really multiproduct firms, right? They don't have a monopoly in every one of their service lines. They try to leverage the monopoly that they have overall, due to reputation or whatever, to negotiate with insurers, but then they clearly maximize their, you know, their margins or their rents by providing more of some services and less of others, and, you know, I work at a medical center, so, I get emails daily from firms telling me how to maximize my billing, or that, you know, I should be doing more procedure X or Y.

It's just clear, it's rampant in the system, and so, what it comes down to is that it's basically all the things you said, Louise. I mean, the -- when you have services that are highly profitable and physicians can threaten, like, especially proceduralists can threaten to go to the hospital across town. They command higher incomes, and the hospitals pay them because they're still making money in those services.

There is waste when people get services that they don't need, or when many, many hospitals are competing to provide those same high-revenues, procedures, for example, and then, you know, there's certainly quality differences and amenity differences. Again, the hospital I work at is not the highest amenity hospital, by far, in the city where I live, but it is the most likely to have that Double Boarded Neonatologist, and I do think that's an amenity that some people value, and sometimes those are the people making the benefits decisions, but those people are not necessarily the median worker who might rather be able to, you know, buy more -- buy more amenities for their children, for example, than had the option value of going to a high quality hospital. So, these are just, you know, 10 answers to the 20 questions you posed, Louise.

MS. PELECH: You could also challenge the idea of choice here, and Amitabh is framing this as like, not to make it personal, but like his personal choice to go to the high-priced hospital, and saying, you know, if I choose to do that, that's my business. I think there's two ways in which that isn't true.

One is that employer sponsored insurance is the second largest tax expenditure in the U.S. Government. So, we exclude mortgages from taxes, and we exclude healthcare premiums from taxes, and that has a really large effect on the Federal budget. So, what we're not spending on teachers or aircraft carriers is what we're spending on health insurance premiums for those people who have good

jobs and good insurance plans, and even within that set of people, premiums are pooled. So, if you have one health plan at Harvard, then Mike is paying for the fact that Amitabh would like to go to the nice hospital, regardless -- because they pay one premium together, regardless of whether that's Mike's preference or not.

So, I think the choice argument when you don't personally face the costs of your own choices breaks down a little bit. I think the last thing I would say about, you know, sort of the OBGYN C-section example is the U.S. has the worst in maternal mortality outcomes of any developed country, and it's actually gotten worse in the past decade rather than better. Louise, this is to your point about some people getting too much healthcare and some people getting not enough. So, it seems that, you know, well-insured mothers are not having these bad outcomes, but then there are people who -- I think it's like half of all births now are given on Medicaid. So, people who don't have access to the nice hospitals are not having good outcomes, and I -- I mean, back to choice. It's a choice of whether we want to have a lot of resources devoted to a subset of people, or whether those resources could be a little more distributed if we had a little more control over how they were allocated.

MS. SHEINER: Can I talk about bending the class curve? So, Melinda, you said, well, we don't want to necessarily bring down the price, we want to just make sure it doesn't grow so much on spending. So, all the things we've been talking about here are really about the level of prices sort of being too high, paying people too much, having, you know, too much market power that leads to higher prices. When you talk about the level not going up, I typically think that over time we think growth is coming from new technologies. So, how do you -- how do you know that we shouldn't be at least continuing to grow, unless we go and fix the things that are causing the level too high? How do you think about that, Melinda?

MS. BUNTIN: Well, we do have methods for introducing new prices for new technologies. So, brand new MRIs, it, once you've got one, it's more expensive. As Amitabh said, lobbying goes in full force. Every academic medical center that wants one is going to argue that they should be paid more for one, and those prices will tend to adjust over time. We're not as good at paying more for a primary care physician when they have to take into account that there's a new diagnostic test or a new treatment. So, we could get better at that.

But fundamentally, we have a lot of ways in which the prices that we pay for things are more tied to cost increases or market power increases than they are to increases in the actual value delivered, for all the reasons we've been talking about for the past 20 minutes. So, I think we can look very carefully at how, in public programs, where prices just have to be set, I mean, we can discuss in detail, I guess, how you might try and key off of private sector prices, but in general, they're set, and then effects of those prices are monitored, so that we, for example, don't have Medicare beneficiaries who can't find a physician or their physicians won't accept them, and we sort of -- we measure the bad outcomes that way, rather than saying prospectively is this a good price? We measure if it's too low.

We almost never have in a system to measure whether something is too high and bring it down. It occasionally happens, but it's very, very rare. So, I think we need to focus on better ways of introducing accurate prices for new services and identifying services that are already overpriced and bringing those services down within our system, and there are actually lots of ways to do that.

I mean, I hate it when people reference their own papers, but literally over a decade ago, I said -- I wrote a paper that looked at the services that were growing the fastest in utilization and whether there was any clinical medical social reason why they should be growing, and for a couple of them there were, and for most of them there weren't. It just seemed that providers were responding to an overpriced service, and you could literally look through the fee schedule and try and find these types of things, and I think more and more private insurers are doing this, they're watching for things that jump out of the data and indicate that they're overpriced, but, again, they don't have a huge incentive to do so.

MS. SHEINER: So, I'm going to turn to audience questions in a second, but I want to sort of get back to Mike's proposal, in a sense. So, I think Amitabh has sort of, I think, made the case the best, that, you know, we took -- it's so complicated. We just don't know. We have terrible measures of prices. They're not really prices. They're a combination of prices and qualities and amenities. People have choice. There is variation of -- there are a whole bunch of reasons why you might say, look, it's really, really, really complicated, and I think what Mike's saying is, yeah, it's really, really complicated, but, boy, a long -- a lot of these metrics, which are all bad, we spend so much -- you know, the variation's high. We pay more than other countries. All of these things that aren't perfect, you kind of get the sense that maybe prices are too high. Why don't we try?

So, it's almost like, well, about which -- should we assume that the market is right, and then just go after the marketing failures, or should we say there's a lot of reasons to think the market isn't right? Let's just see what happens if we start, like, step, you know, cutting down on the highest ones, and then -- and go from there. Amitabh, what do you think about that, that it's a different approach, without sort of saying, oh, it's not complicated?

MR. CHANDRA: I think my worry with it is it won't be a whole lot of lost welfare. If you started at the \$40,000 place, you just wouldn't know where to stop. So, I think, you know, would you stop -- you'd always -- if the rule is let's always whack the person at the 99th percentile, should we whack the person at the 99 -- if you're above the 99th percentile, we whack you. Is that the rule? And it -- you know, what would be the welfare consequence of that?

People will say it's going to be very small. Yeah, it's going to be very small until you whack that price. Then, the 98th percentile guy becomes the 99th percentile guy, and you whack that price, too, and then the guy, you know, at some point, the guy at the 75th percentile becomes the 99th percentile guy. Where does it stop? If we're not measuring the outcome, where does it stop? And we have this sense that, like, again, the PhD economist is so moderate in their view that they would know where to stop, but I think the importance of that is we wouldn't know where to stop because we're not measuring value, and much more problematic, as the commercial sector becomes smaller and smaller, and the government prices become a larger share of all prices, we worry seriously about monopsonistic prices, and that will have first order effects on quality.

So, I just want to share this one graph that's not mine. It's another stolen graph, from Amanda Starc and Craig Garthwaite, have a working paper in the NBER. It's not my work, but it's intriguing to me, and I think it kind of highlights my worry. It shows us the association between six measures of quality and the predicted private share of patients at a hospital. So, it's a hospital level analysis, and every circle is a ventype.

So, as you move into hospitals where a greater share of their patients are private, quality goes up, as measured by hospital compare, or, you know, the presence of technology, or the share of cardiologists from top medical schools, or risk adjusted outcomes from heart attacks, or time in the E.D. for patients who were eventually admitted. That goes down, which is a good thing. It's just a small way

of saying we don't really know how to do any of this, and so, if we go down the price regulation route, very quickly, what we're doing is we're not just whacking the person at the -- who is offering the \$40,000 cesarean. We're also increasing the public market's share in healthcare, which will have quality effects, of these six types, right?

Now, we need more of this work, but I'm not the one with this policy proposal. I would much rather take another view of this, which is another option that Mike gave us, narrow networks, reference pricing, get rid of the EHI. That would be my way of doing it, more than saying we know that the problems are only at the 99th percentile.

MS. SHEINER: Mike, can you --?

MR. CHERNEW: First of all, if you regulate the 99th percent, the 75th percent person doesn't become the 99th percent. You just get a bigger mass at where the 99th percentile was, but that's a separate math point. The broader point is, in terms of where you stop, sure, that becomes a public policy debate about where you stop. I think my complaint is that we're not putting enough weight on the really serious deleterious distortionary consequences of the existing pricing system, and the difficulty in doing -- in all of the various what I'll call pro-competitive things, which I support, work. We can have reference pricing now.

We should spend more time -- we can have another Uwe conference on what's wrong with the employer system and where the market failures are there, which I think they're enormous, but the point is I'm much less worried about where to stop than getting us actually started. If we could deal with surprise billing, that's where I would start, by the way. You know, if we could deal with -- I don't think you can argue anything about surprise billing, except that there's a market failure there. We need to be able to solve that problem. I think that's pretty clear where it is. I will worry about where to stop once we get through the most egregious ones, but I think the political -- I have enough confidence the political process will be able to get us to stop some place that is reasonable.

MS. SHEINER: Yeah, so, you --

MR. CHANDRA: Only if you have a commercial industry lab, Michael, and you need a commercial industry. If you get rid of the (overtalking).

MR. CHERNEW: Sorry.

MR. CHANDRA: Yeah, yeah. The commercial insurance industry. The commercial industry that I think adds -- you know, I think -- I think there's a sense in what we're saying, that it's not doing its job, when -- you know, we also write lots of papers saying employers pay for their benefits in the form of lower wages. So, employer, employees, as long as they have a choice, I don't see how employers have figured out how to help themselves to workers' paychecks. I just -- I have not figured out how that works.

MR. CHERNEW: This is the last point, Louise, I promise. The biggest threat, in my view, to the commercial insurance sector is the inability to have the public sector help them with the upper level prices. All the threats of the commercial sector, public option, all that stuff, is because the prices are so disparate between the public and the commercial sector that you're going to lose the commercial sector that way, much more quickly than you would lose the commercial sector if you could help them get rid of some of the biggest market failures.

MS. SHEINER: Okay, I'm going to bring up some audience questions. Forgive me, my dog got out of the tent I put him in, and he's now barking, but hopefully he'll stop. So, there were a number of questions going back to these international comparisons, and it asked me about the educational requirements, both in terms of paying for school and how long it takes to become a medical professional and whether or not, you know, part of the reason that people make a lot of money is because it's so expensive to become a doctor, you know, it takes so long, and so, they feel like it should be (inaudible) money.

Does anybody have a sense of -- also this old world question about whether or not, you know, we should be seeing more stuff going over to PA's and nurses, and whether or not doctors are having a monopoly that's keeping spending very high. Does anybody have a thought on that?

MR. CHANDRA: I have a small thought. It's not my thought. It's, you know, in -- it's a working paper I came -- saw from the NBER, which is this -- there's no question that I think medical education is probably fairly dated and doesn't need to be as super specialized, you know, and all of that, but the first order, it is true that American doctors are paid more than, say, Canadian doctors. I think American specialists are paid about 40 percent more than Canadian specialists, but I think what people forget is a lot of this just reflects the American wage structure. Computer programmers in America are

paid 35 percent more than computer programmers in Canada. Electrical engineers in America are paid 30 percent more. Petroleum engineers are paid double in America.

A lot of it has to do with, like, the alternative sector, which might be law or finance, where wages are much higher. So, I don't think the first order story is training and the length of training. Oh, I'm not saying it isn't important. I'm just saying the first order story is wage inequality in America.

MR. CHERNEW: So --

MS. PELECH: Well -- go ahead, Mike.

MR. CHERNEW: I agree with Amitabh, but the first order of problem is facility prices and facility things, and I'm much less worried about professional prices along that suffrage.

MS. PELECH: One thing that I would say to Amitabh's point about training is that over the summer I started thinking about how we might increase the supply of doctors in the United States on that, through Federal policy, and it became clear that it wasn't really Federal policy where the action was, it was state policy. So, I did not know that to be a doctor in the U.S. you had to do either a U.S. or Canadian residency. You can be trained in Sweden, and that's too damn bad. You can't come be a doctor in the U.S., and I don't know if that's because we think doctors in Sweden aren't very good, or if it's because medical societies in states have a lot of pull in state houses and they are able to make those sorts of choices about what it is to be a doctor in the U.S.

MS. SHEINER: So, we talked about facilities. We talked about hospitals. We had a lot of questions also about prescription drugs, and Mei showed us -- showed a slide about how much more we pay for prescription drugs. Is that a big part of this story, and how do you think about those prices and efficiency and importance of getting them down or not? Anybody? Melinda? Any --?

MS. BUNTIN: I'll start. The only thing I was going to add on medical education is, as far as I can tell, even though U.S. medical education is expensive and people talk a lot about incurring a lot of debts, the literature I've seen indicates that you still get a pretty great return on investment from that, at education. So, you know, it's a little bit of a circular argument, but it's not as if prices have to be as high as they are to justify that education costs are getting a good return.

So, then the question is prescription drugs. It is undoubtedly true that you can do lots of the comparisons if we'd had slides that Amitabh and Mike, would have shown, that had comparisons of

drugs. It would have been probably even more dramatic across the world how much more we pay for prescription drugs on average than people in other countries, where they're negotiated centrally. I will say that that's an issue, but prescription drugs adds sort of a slice of the pie, have grown. They're not the whole story. So, I think we can dwell too much on prescription drugs.

The other thing about prescription drugs is that there are lots of prescription drugs that really do deliver a high value. So, I think that's the way we should be thinking about everything. I guess I'm one of those people who's still on the value bandwagon, but there are lots of drugs that substitute for healthcare services and there are lots of drugs that are clearly worth what we're paying for, even if it's a lot of money. So, I think to the extent that other countries explicitly consider those things when deciding whether to cover the drug and at what price, we could learn something, but, again, like, there's -- it's -- there's no sole single silver bullet in this entire price discussion. It's not like we solved that problem, we're done.

MR. CHANDRA: Can I just add to what Melinda said, which is -- I agree with everything she said. I think the big question with prescription drugs is what incentives do we need to give manufacturers for the drugs that society really wants, simply because we have it. Not every drug needed all the incentives that we gave it to come to market. A lot of those drugs were inframarginal drugs, and a lot of drugs didn't come to market because we didn't have incentives to induce them, right, and it's one of the hardest problems out there.

How do you design an intellectual property system to get us the right drugs? That's the harder question that I think we should be focused on, more than like the drugs being a silver bullet, short of the drugs that don't go generic. I think that, there, I actually agree with Mike, and regulation. There is a variety of drugs that have not gone generic, where manufacturers have broken the social contract. There, I think we need heavy regulation, and I'm not worried about quality because we're talking about, like, literally the same drug made in the same facility.

MS. SHEINER: All right, Mike, you get the last word, and then we're going to wrap up. You got 30 seconds, but you're on -- you're muted.

MR. CHERNEW: I agree with Amitabh. On that, I agree with Amitabh.

MS. BUNTIN: On that point.

MS. SHEINER: Well, yay. Ah, I love that. Okay. Thank you, all of you, panelists, for a really lively discussion, and for at least bringing out all the areas of disagreement and ending on an area of agreement. Let me remind everybody that the next webinar is Wednesday, September 23, at 2:00 p.m., and it is titled "Healthcare Price Regulation and Public Options: Assessing Approaches to Increasing the Public Role", and look forward to seeing you all then. Thank you very much for joining us.

MR. CHERNEW: Thank you.

MS. BUNTIN: Thank you.

MS. PELECH: That was great. Thank you.

MR. CHERNEW: Thanks, Louise.

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