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HOW TO LOWER HEALTH CARE COSTS: COMPETITION, REGULATION,  
AND ADMINISTRATIVE EXPENSES

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ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190

PARTICIPANTS:

**Welcome and Introductory Remarks**

JAY SHAMBAUGH  
Director, The Hamilton Project, Senior Fellow,  
Economic Studies, The Brookings Institution

**Roundtable discussion: What is the best approach to  
directly regulate prices to lower health care costs?**

LEEMORE S. DAFNY  
Bruce V. Rauner Professor of Business  
Administration, Harvard Business School

MICHAEL E. CHERNEW  
Leonard D. Schaeffer Professor of Health Care  
Policy, Department of Health Care Policy, Harvard  
University Medical School

AMITABH CHANDRA  
Ethel Zimmerman Wiener Professor of Public Policy,  
Director, Health Policy Research, Harvard Kennedy  
School

**Moderator:**

JULIE APPLEBY  
Senior Correspondent, *Kaiser Health News*

**Research presentation: How to lower administrative  
expenses**

DAVID CUTLER  
Otto Eckstein Professor of Applied Economics,  
Harvard University

**Roundtable discussion: How can increased competition  
reduce health care costs?**

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MARTIN GAYNOR

E. J. Barone University Professor of Economics and  
Public Policy, Carnegie Mellon University

ELIZABETH FOWLER

Executive Vice President for Programs, The  
Commonwealth Fund

PAUL GINSBURG

Director, USC-Brookings Schaeffer Initiative for  
Health Policy; Leonard D. Schaeffer Chair in Health  
Policy Studies; Senior Fellow, Economic Studies,  
The Brookings Institution

NOAH J. PHILLIPS

Commissioner, U.S. Federal Trade Commission

JAY SHAMBAUGH

Director, The Hamilton Project, Senior Fellow,  
Economic Studies, The Brookings Institution

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## P R O C E E D I N G S

MR. SHAMBAUGH: Good afternoon, my name is Jay Shambaugh and I'm the Director of the Hamilton Project at Brookings. I'd like to welcome you to this event, now webcast, "How to Lower Health Care Costs: Competition, Regulation, and Administrative Expenses".

First, I'd like to address the obvious -- this even was supposed to be an in-person event with a webcast as an additional access point. As of yesterday the Brookings Institution has suspended large in-person events, in the words of the President of Brookings, "Given the escalating nature of COVID-19, we are taking a number of actions aimed at mitigating community spread to employees and our institution." And so, with that, we are continuing this event, but as a webcast only event. So thank you very much for joining us this afternoon.

I'd also like to thank the people who have come to be with us here at Brookings to be on the panel and then also thank very much the people who are in a studio in Massachusetts who will be part of another panel. And I'd like to ask any forgiveness from you,

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the audience, if there are any glitches as we try to bounce back and forth between the people here in D.C. and those in Massachusetts.

The Hamilton Project team, most notably, Melanie Gilarsky, our events and outreach manager, and Kriston McIntosh, our managing director, have worked very hard and very quickly, along with a terrific Brookings tech team, to make sure we can carry on this event. So I'd like to thank them.

So as to the event itself, it may seem a little odd to bring together some of the best minds in health economics during a health crisis and not just talk about that crisis, but in many ways this outbreak has been somewhat revealing to some of the challenges we all know exist in the U.S. health care system, those around access, around coverage, and around costs that can make dealing with any kind of health even more challenging.

More broadly, it's clear from the political debates around health care that there are real questions about how to provide health care coverage and access to people. But, at the same time, the United States has a

clear problem with cost in the health care system, and we're going to focus on that second piece here today. And, in particular, focus on the prices in our health care system. And for those of you wondering the difference between cost and price, you could think of the health care costs in our system as being something about how much health care we use times the price, whereas the price is just that second piece.

We're going to examine why the United States has such high health care prices and if something can be done about it.

So to accompany this event we're releasing three policy proposals that you can find on the Hamilton Project website, along with a set of economic facts about the U.S. healthcare system. In that latter document, we look at the rising costs of U.S. health care, that fact that U.S. health care spending has gone from about 5 percent of GDP to close to 18 percent of GDP over the last half century. Some of that is natural -- as an economy gets richer, you expect to spend more on health care, but some of it seems to reflect problems in health care markets.

Public held expenditures are now almost 25 percent of overall government expenditures, which signals a lot of pressure from health care on the overall public finance system.

We also note that we pay more in total health care costs and we pay higher prices than virtually any other country. We also see wide variation in costs and prices, both across areas, and even within markets. And relevant to the proposals today, administrative costs are quite high and competition seems to be quite low in many aspects of the U.S. health care system.

So to address these issues we've assembled a terrific set of authors who have tried to explain how they think we should address these challenges and what changes they would make to the U.S. system to lower health care costs. We also have some great panelists who are going to shed some light on these topics as well.

So I'd like to close just by thanking the Hamilton Project team. A lot of work goes into these events and into these papers. In particular, I'd like to once again thank Melanie and Kriston, I'd like to

thank our outstanding policy director, Ryan Nunn, for all his work, including co-authoring that facts document, and also our research analyst, Jana Parsons, who has played point on this project overall and is also a co-author of that facts document.

We would love audience participation. You're obviously not in the room with us, but you can be with us virtually. So if you have any questions, you can Tweet them to @HamiltonProj and you can also Tweet using #Healthcarecosts. And we have a team who will be monitoring those two things and they'll write down any questions you have on an index card and pass them along to the moderators of the panels.

With that, I'd like to turn it over to Julie Appleby, who is a Senior Correspondent with Kaiser Health News, who will moderate the next panel where there will be a set of panelists who are all in a studio in Massachusetts.

MS. APPLEBY: Thank you very much. Thank you for having me here. I'll welcome the audience; I'm glad you're participating, even if it's virtual. This is a new world for us, but here we are.

I want to start out just by setting the state for this particular panel discussion. I recently was cleaning out some rooms in my house and came across one of the first stories I ever wrote as a health policy reporter years ago. At the time, hospitals were closing, the number of uninsured was rising, health insurance premiums were going up by double digits, in California, where I lived at the time, there was a county that was looking at how to slow health care costs, particularly for the uninsured and those on government programs.

Should priorities be set with some treatments and conditions getting covered and others not? Eventually, the county decided not to do that, saying it didn't want to get involved in over rationing of care. At the time, the U.S. was spending about \$2,000 per capita on health care costs and national health expenditures were about 11.6 percent of the GDP.

Flash forward to today, health spending is now about \$11,000 per person and its share of GDP is close to 18 percent. Premium growth for employer plans is certainly not in the double digits, but still family

coverage offered by employers averages more than \$20,000 a year.

But in the intervening years we've seen a lot of attempts to slow rising spending and prices. Managed care became dominant, deductibles grew as employers shifted some cost and tried to have workers have some skin in the game, tiered and narrow networks have had their moments. Still, prices continued to rise.

So the question today is still just as relevant as it was at the start of my career, how to control spending and prices while not stifling quality or access.

Today we have three notable health policy experts who will talk with us about regulating prices. While Medicare and Medicaid have set prices for decades, it's rare in the commercial market. Is it time for such regulation? And what would it look like?

So joining us today we have Leemore Dafny, who is a Professor of Business Administration at Harvard Business School, Michael Chernew, who is Professor of Health Care Policy at Harvard University Medical School, and Amitabh Chandra, who is a Professor of Public Policy

and a Director of Health Policy Research at Harvard's Kennedy School.

So we welcome the panelists.

And I am going to start with you, Leemore. You've done a paper and I understand that you think the way to address high health care costs and prices is to prohibit the highest of these prices.

Can you explain what you have in mind and why?

MS. DAFNY: Absolutely. And I just want to preface that by thanking the Brookings Institute and particularly Jay Shambaugh and Ryan Nunn for the opportunity to think about this very difficult question.

So to answer your question, let me start by talking about why I think these high health care prices need to be addressed and co-authored this proposal with Michael Chernew to my left and with Max Pany here at Harvard.

The reason is that in recent years the growth in health care spending is primarily due to growth in prices. Data from the Health Care Cost Institute shows that about three-quarters of the spending growth for a commercially insured person is due to an increase in

prices. And there's no evidence that that increase in prices is associated with improvements in quality. In fact, there's a lot of evidence that higher prices are driven by greater market power, and more consolidation in market power is in fact linked with lower quality, not higher quality. Now, competition can work to restrain prices, but so many of our markets are not competitive and we're seeing some incredibly high prices as a result.

So that's the "why". We go straight for the jugular and we go for prices. We have a proposal to address this that has three prongs, okay. Prong number one is a cap on prices. Prong number two is a cap on price growth. And prong number three is flexible regulatory oversight. Now, I'm going to dial into some of the details and begin with the cap on prices, okay.

So we propose a cap on health care service prices. So these would be health care providers, facilities, as well as practitioners. Our cap, we propose that it pertain both to in network and out of network services. And we also propose to base that cap on commercial prices in your local market areas.

Specifically, we suggest that one take a multiple of the 20th percentile of prices for each service in that area and cap prices at that multiple.

So to give an example, if the 20th percentile negotiated price for a cesarean section in the San Francisco Metro area is around \$12,000, we propose that you be allowed to charge a price that is more than 5 times that amount. So we're talking more than \$60,000 would be prohibited by our proposal. So it's important to note that our caps are really aimed at the most extreme prices, 5 times the 20th percentile, 20th percentile for inpatient services, around 130 percent of Medicare. So we're talking very, very high price caps.

We also propose a cap on the growth rate of prices. This has the benefit of affecting prices throughout the price distribution, not just at the very top, because we believe that something needs to be done about the very steep price growth. And this would operate on all providers, even below the cap, and it could be set at something as generous as policy makers want, to allow for more investment in health care, if that's what we desire, perhaps something like the

Consumer Price Index plus 2 percent.

And let me move to the third prong, which is flexible regulatory oversight. Now, we could spend some amount of time talking about that, but a couple of just important points to note there is that in order to implement these price caps and monitor prices and price growth, we're going to need comprehensive data on commercial insurance claims. So that's a requirement. And then beyond that we need authorities to be monitoring that data and to react when there is a trigger that suggests that this price regulation is not working as intended, perhaps it's being evaded. And that would require creation potentially, or at least appointment of existing state authorities, likely some Federal authorities, to do some of this monitoring and assist with the review process when the trigger is tripped.

So I'll pause there.

MS. APPLEBY: Thank you. There's a lot of moving parts there. We're going to get to some of them, but let me just quickly turn to Michael.

You know, this is a pretty heavy handed

regulatory approach. So why do you prefer this to other alternatives? Just briefly. And then we're also going to get to some of these details, but why do you prefer this to other approaches?

MR. CHERNEW: So, first of all, I'm thrilled to be here, and thanks to the Brookings folks for having us and asking us to look into this question.

Let me start, before describing the specifics of our proposal, by emphasizing one very important point. And I think it came up in Jay's intro, it came up in Leemore's comments -- we believe that we need to act. The problem with rising spending largely due to rising prices in the commercial sector, isn't simply an issue of high health care spending in the country. There's a response from employers, they tend to, for example, raise the amount that patients have to pay out of pocket. When that happens, patients don't get needed care. There's a lot of financial burden. So if we don't address this problem, there are actually really real consequences for Americans overall in what they have to pay and how they can access health care.

So once you buy into -- and everybody may not

-- but once you buy into the premise we have to act, there are two broad questions. The first one is how strong should that action be, and the second one is what form should that action take.

So with regard to how strong the action should be, you characterized our proposal as a heavy handed regulatory approach, and I appreciate that. It's not the words I would use, but nevertheless, I actually think in many ways it's quite weak and I'll explain why in a bit. But when you compare it to many alternatives, I think you'll find that what we've done is quite weak. And I would also add that when we talk about some of the specifics, most of them are modifiable on a whole range of ways. You can make our approach weaker or stronger by tweaking aspects of the parameters that we don't have a particular strong sense of where they should be.

So now let me turn to the sort of maybe meat of your question, which is why we chose the features we did. Essentially, why did we peak this regulatory approach. So there are several other alternatives -- I can't mention all of them. In fact, when I said several, I really meant an infinite number of other

alternatives. So one approach, for example, would be to just let competition work and do a number of reforms to promote competition, things like transparency in a number of contractual changes. And I think the panel after ours is going to discuss that, so I encourage everybody to stay around and listen to that. And you should know that neither Leemore nor I nor Max -- I don't mean to speak too much for Max -- are really strong pro regulatory economists. I think we both believe that markets should be allowed to work, it's just the evidence suggests that right now they're not working well. And so we wanted to design a proposal that would allow that type of competition to flourish, but in the meantime -- because, frankly, I'm a little skeptical about how impactful that would be -- to be able to cut out the most egregious problems. And that's essentially what we're doing with the price caps, cutting out the most egregious problems.

The second question you might ask is if you believe that competition alone or reforms to competition won't act quick enough or won't be strong enough, why don't you go to a much bolder proposal. And, again,

there are many other options. The one that probably has gotten the most attention are variants of public option proposals. There's a whole range of those types of proposals. And so I'm going to interpret your question as asking why didn't we just go straight to a public option. And I will tell you, there are some virtues of a public option we could talk about at some length, but the main issues I think with the public option are that when one creates a public plan, you could -- it actually turns out to be much stronger. You have to pick a price that the public plan is going to pay. If you want that public plan to save any money, the prices have to be lower than the average prices are now. So whereas we have a cap that's loosely, you know -- well, it is 5 times the 20th percentile in your market, public option proposals are much less. They're often Medicare times 150 percent. That's much, much lower.

So whatever you worried about on our proposal in terms of its impact on providers, a public option plan would be much stronger and it would in fact raise the prices potentially for providers that are underneath that cap. So that ends up becoming a concern.

The other problem I think is important in a public option type model is that you have to worry about stability in the insurance market. So there's many public option proposals that limit who's eligible -- only offered on the exchange, for example, or only to small businesses -- things of that nature, which is okay. The problem is that puts even more pressure on folks not allowed into the public option, so that becomes a problem. And if you make the public option favorable and you make it available to all, you have to worry about broad availability of insurance outside of the public option.

Now, many people might think that's fine, that would push us much closer to a single payer system, and we could have a discussion about that. I think our view was we were not yet ready to say that we should abandon the role of private insurers in the health care sector. We wanted to come up with a proposal that enabled competition and private insurers to continue to work on the problem of high health care prices and high health care spending without having to move to a system where we have much more government involvement and deal with a

whole range of other problems that associate with that.

And last --

MS. APPLEBY: Okay. Thank you, Michael.

Let me turn to Amitabh for just a second though. Let's jump into what are some of the challenges with this type of proposal in your mind?

MR. CHANDRA: So I think the challenge is really -- there's two challenges. One is something that Michael spoke about, you know, is the 5X number the right number. So if you make it, you know, 10X, if you make it 10 times the 20th percentile, then you don't do much. And if you make it twice or, you know, 5 percent of the 20th percentile, now it's going to have a lot of bite. And they don't take a particular stance. I think in the proposal they say well, we think 5 times the 20th percentile is the right number, and we're not sort of strongly wedded to that 5X number. But I think we have to think about what that multiple of the 20th percentile has to be, right.

And here's why we have to think about it. The higher we go, so the more we make -- you know, 7 times the 20th percentile, the less we'll do, the lower we'll

make it. My view is the more we are likely to cut quality. And let me explain. So I'm very much of the view that when providers consolidate, quality does not go up. So I very much share your view of that fact. But it does not follow that providers who are at 5 times the 20th percentile are the providers whose quality is not better. That doesn't follow. So high prices are not always a consequence of consolidation. They could be a consequence of quality.

And when I read your proposal, I noticed again and again you point to the terrific work that Zach Cooper and Marty Gaynor and John Van Reenen have done on showing the importance of monopoly power, but that same works shows again and again that higher prices are correlated with better quality.

So I'm looking at the work you're citing as an example of gee, higher prices don't reflect better quality. And I'm saying, no, the work you're citing actually says higher prices are correlated with better quality. Maybe that better quality isn't worth it and things like that. Let's give people options. I'm all for that. I'm not saying that markets are working here

terrifically well, but I am saying we are going to have quality effects. And the fact that very wealthy people in Boston are willing to pay extra to go to these high priced providers is not a sign to me that they were forced to go to these high priced providers. There was something about these high providers that drew them to them, which is one reason that these high priced providers may actually have a fair bit of monopoly power. It could be that small improvements in quality actually create local monopolies.

And so those are all the issues that we have to grapple with. And these are the same issues that, you know, a public option would have to grapple with.

And so, again, in summary, it's very much my view, influenced by your work, that more consolidation doesn't mean higher prices, but from that work, it doesn't follow that all the higher prices are a result of more consolidation.

MS. DAFNY: Julie, if I may, Michael and I are debating which of us gets to answer, and I'll defer to him and then chime in if that's all right.

MR. CHERNEW: We could do rock, paper,

scissors.

MS. APPLEBY: Yeah, let's talk about the issue of quality.

So, Michael, what's your response?

MR. CHERNEW: Yeah, so a few things.

The research on the relationship to between price and quality is much less consistent than the way Amitabh portrays it. Even Zach's work -- and I've actually done some work on Zach, for example, price differences for selected services, and found for commoditized services there was no impact on quality. And I think the key question, which Amitabh raises appropriately, is what would the impact on quality be if we tried to cut the very top level of prices down.

So I believe that the reason why -- if you thought you needed higher prices to get to higher quality, that may well be true, I'm not convinced that that's true when you get to five or six times of where Medicare prices is, five times of where the local market is. And much of that work is actually work on spending and quality. And some of the price work, of which there is some, talks about lowering Medicare prices, which is

actually moving it a point in the price distribution well below where we're talking about acting.

So I suppose one could take the view that we either need to wait to act until we know exactly what's going on, or that we need to be even weaker than our current proposal, that is reasonable. I would argue that if we stick with the status quo and wait for things to play out, the quality problems that we need to worry about are the quality problems that arise by the reactions that will result from where prices are and that overall health would be better if we control spending, because that would reduce a whole number of other things that have much broader health effects than worrying about an organization charging, you know, six times Medicare or five times the twentieth percentile.

And if you were very concerned about Amitabh's point, a few things you (inaudible) from a public option and then we could argue, okay, so you don't think it's five, okay, let's go to six, and let's go to six and see.

MS. DAFNY: You know, a point I'll add is if these prices can continue without restraint, that

provides an incentive to merge in order to increase price. And we know, right, that mergers are followed by price increases, but not by quality improvements.

So if you wanted to try to mitigate or minimize the incentive to engage in these price increasing maneuvers, then saying, okay, at the very, very tail end of these we're going to say stop here. And nobody would deny that there's not a tradeoff.

MR. CHERNEW: Right.

MS. DAFNY: There's some sort of tradeoff -- we don't know exactly. But sometimes you say, well, if you can't produce it at five or six times, what others can, you know, then maybe we're just going to take that chance.

MR. CHANDRA: So, look, if we knew that at five or six times the quality was the same, then should we implement your proposal? Absolutely, we should implement your proposal, right, go ahead with it. Like let's just say maybe there's no such difference in amenities and thinks like that.

But in the Cooper work, he's looking at prices.

MS. DAFNY: But the Cooper work has an association. It doesn't -- I don't want to get too far in the weeds, but it doesn't at all establish that an increase in price leads to an increase in quality.

MR. CHANDRA: No, but he shows --

MS. DAFNY: They have a control variable in there that shows that there's a correlate, and --

MR. CHANDRA: But it's the evidence you cite. It's the evidence that you cite again and again as evidence that higher prices don't mean better quality. And I keep saying because you're pointing to the monopoly party of that paper.

But there is this other part of the paper which says that places with higher prices -- prices, not spending -- are less likely to do very simple things, like give their heart attack patients aspirin at the time of arrival, or antibiotics within, you know, one hour of surgery. So these are things that even economists know how to do, so why is that the places with lower prices are less able to do this?

MR. CHERNEW: Again, there's a question about whether we're pulling out things at the top end of the

distribution, or pulling out things in the middle. So a lot of that work is really at a different point in the distribution were we're talking about. So the way that we reconcile -- or that I reconcile the tension between where we see mergers we don't see quality get better is because what mergers are doing is pushing you up on price at a different margin of where price is going, whereas a lot of the associational work is looking what's happening at average prices and what's going on and it's driven by a completely different variation of where prices are.

I don't think any of us would disagree that (a) quality is important. I think it -- as Amitabh noted, we write about it and we worry about it in what we do, and I think both Leemore and I would worry about it. The question is really what's the consequence of not acting. So back to how I set this up. If you agree that prices are associated with quality and you say therefore we can't go after revenue at all, that puts you into a whole series of other problems -- much of it would relate to quality.

So then you say, all right, now we have to do

something. What are we going to do? You could take our proposal and say, you know, your proposal is perfect, just move to six times instead of five times -- or some variant of that.

MR. CHANDRA: Well, no, you could take your proposal, Michael, and say prices are a problem, but you don't have to use the regulatory hammer to fix prices, right. You could give patients choice through some kind of --

MR. CHERNEW: Yeah.

MR. CHANDRA: -- narrow network or reference pricing and say, if you want to go to the hospital that charges \$60,000 --

MS. DAFNY: So let me ask you a question.

MR. CHANDRA: Yeah.

MS. DAFNY: So I'm a fan of narrow networks and --

MR. CHERNEW: She is.

MR. CHANDRA: Yeah.

MS. DAFNY: -- tiered networks.

MR. CHANDRA: But that's a very different approach.

MS. DAFNY: Right, it is a very different approach and it's not working.

MR. CHANDRA: But we haven't really tried them.

MS. DAFNY: You know what, but it exists and part of the reason we haven't really tried is because of all of the market failures that intervene between any individual making a choice and having access to a plan that looks like that, because, as you know, it's intermediated through our employers.

So I want us in fact to be in a world where we have more agency over our insurance plan and have greater choice over health plans. But that's not the world we're in. So rather than continue to write about the world I wish there were, I'm out there saying, you know what, given the world that we're in and the harm that is arising and the intent that this is creating, it is too broken to keep talking about the world I wish that there were.

MR. CHERNEW: And to make this not so much about Harvard economists talking to each other, I will add there is work that's been done reference pricing.

Two things about -- the best work I think is -- James Robinson and Chris Whaley have done some -- they've found a few things. One is they find big effects, both on where people go get care, and they find a price effect and they find no quality change, by the way, when the price went down in that particular work. And then Attig Morocha (phonetic) and Anna Sinaiko, two other colleagues of ours, did some work that explained why those types of models don't diffuse.

So it is the case -- and again I encourage everybody to stay for Marty's panel -- that will -- you know, we should have had Marty here -- unfortunately he's not in Boston -- to look at the type of pro-competitive things that Amitabh's discussing, all of which I think Leemore and I would agree with and be supportive of. The question is, should we continue to sit back and let the world evolve and hope that all of that works, or should we take some action now.

I think Amitabh in some ways is arguing that our proposal is too strong, which is a reasonable view. And I hope that everybody who thinks that it's too weak listens to Amitabh (laughter). I've heard from a number

of others, particularly fans of public option and other types of proposals, that our proposal is way too strong.

So it is the case that we are to some extent a middle ground.

MS. DAFNY: Way too weak.

MR. CHERNEW: And you can -- we've designed it to both be titratable, to be modifiable, and to give room for the pro-competitive things that Amitabh talks about to take hold. But what we haven't done is taken the view that we should wait and see how things play out.

And I really -- yeah, go on.

MS. APPLEBY: So I've got a question. This is a great robust discussion and I'm going to encourage the audience again to Tweet in your questions, and we'll get to those in a little bit, but explain how would this go into effect. Is this going to require some kind of legislation? Or how would this be implemented?

MS. DAFNY: There's a whole range of implementation details, and I don't want to trivialize them by calling it that. We fully recognize that this is a big picture proposal and we have sketched out --

it's available now on line in the proposal -- some of the implementation requirements, but it's certainly not drafted in a way that is, you know, ready to go legislative language.

That said, there are a couple of things that we know we'll require. We're going to require comprehensive data. Otherwise we can't even monitor what's happening to prices. That's a problem already today for researchers and for policy makers. That would likely require Federal action to ensure that employers who self-insure their health plans, that their claims are included when insurers are mandated to submit them to state or Federal agencies.

So there's probably Federal legislation that will be required for us to get a reasonable sample, a representative sample of claims data.

Second is that the states have a lot of infrastructure that engages in monitoring of the health care system. There are departments of insurance, there are departments of health. Now these departments would be asked to do some monitoring. And I think at state option they can decide how aggressively they want to --

if they want to have the caps, how aggressive they should be and how extensive the monitoring ought to be. But one would need to have authorities who are tasked with doing that and given a budget.

So those are, I think, the key components.

MS. APPLEBY: And would these be caps on what hospitals can charge or what insurers could pay, or both?

MS. DAFNY: Ultimately both. Whatever is most expedient and effective for the legislators in the given area to establish.

MR. CHERNEW: In a state based system, there's limits on what insurers can be regulated through a program called -- or a law called ERISA. So you have to focus on that. And much of the enforcement mechanisms that we've looked at, and even the growth stuff, has been tried. The growth caps have been tried in Rhode Island -- a variant of them, Massachusetts has a version of the flexible regulatory oversight. That's a little bit weaker than what we're proposing, but it's been done. David Cutler is coming to speak next. He's actually on the Health Policy Commission that implements

that.

And by moving this away from a connection to Medicare -- which is another point worth discussing -- that by not connecting it to Medicare will remove some of the other challenges that we think might otherwise have arisen. Of course we've created different challenges.

MS. APPLEBY: So, Amitabh, I'm interested in this issue of price transparency and market forces.

So there's a move the Trump Administration has made to require hospitals to post their negotiated prices for services and for insurers to provide consumers with better tools to figure out what it might cost them to see a doctor, have surgery, or whatever. Court battles are expected over this, but let's say it goes into effect and they have to post their negotiated prices, would that mean we wouldn't need a proposal like Leemore and Michael are putting here because the prices would be transparent, people could decide where to shop, employers could decide which providers to sign on with, that type of thing? Or would that not help resolve some of these issues?

MR. CHANDRA: So I wish that, you know, shopping for hospital care was like shopping for cars and computers, and if we just posted the prices people would go and shop.

My strong sense is that to the extent that there will be some shopping that happens, it probably will not be led by patients. But there are two other groups who might respond to that data on negotiated prices. So one, as you said, employers might respond. They might find it a little bit easier to build that narrow network, right. Certainly, it's not going to be harder to build a narrow network. But, second, I think that a lot of Mike's earlier work on what happens when you capitate physician groups in a sense, that could be a mechanism by which we lower the cost of health care. So if a physician group -- you know, if a physical led ACO was receiving a fixed amount of money to take care of a pool of patients and they knew that it was six times more expensive to send a patient to a particular large marquee academic medical center in Boston as opposed to, you know, another hospital that's six times cheaper, they would have a strong incentive to refer

their patients to the cheaper hospital that's just as good. But they wouldn't know that without better data on what they would pay if the patient went to the expensive hospital versus the cheaper hospital that's just as good.

So I think -- I think these ideas can help. I'm not convinced that the agent here will be the patient. I'm a lot more -- you know, I updated a lot from Mike's earlier work on the AQC in Massachusetts, and when I read that work I thought the takeaway was very much that the agents here could be physicians. And I think the untapped agents are the ERISA plans themselves. So employers could really look at the variation and say maybe we'll build a narrow network in Boston or we'll build a narrow network in Washington, D.C. or Chicago or San Francisco. Well, we'll let you go to the really expensive hospital, but only for the following three things. And for everything else you go to these other hospitals. And if you want to go to the really expensive hospital, you can go, but then, you know, you're paying that extra very high co-insurance rate.

MR. CHERNEW: Amitabh is being a little modest. He's done some of the seminal work on how these consumer directed health plans that were intended to allow people to shop actually didn't get them to shop. It did get them to use less care, suggesting if you just charge them more -- because prices are going up -- they use less care. They certainly don't shop.

The bit of payment reform and control and spending I do think is very important. We can have another discussion about that.

I'm a little less optimistic about that insurers use -- and employers need to use the data. As someone who serves on the Harvard Benefits Committee, actually with Leemore as well, we actually might -- we know what the negotiated rates are. We don't need to have them posted and mandated to be posted. We know what they are because we have carriers that can tell us. So if we wanted to do a narrow network or a reference for pricing plan, there's more than enough information out there now for us to do them. We're actually not quite ready to do that.

MS. DAFNY: And I'll jump in and say that

Michael is being modest. Together with Zach Cooper he's done some recent work on price shopping by consumers, but also by informed referring providers, and doesn't find any evidence that the referring providers are directing their imaging and whatnot to the lower cost facilities.

MR. CHERNEW: Because they didn't have the incentives Amitabh was talking about.

MR. CHANDRA: Yeah.

MS. DAFNY: Because there is a lack of incentives.

MR. CHANDRA: Yes. But so we can fix the incentives problem, I think, through these physician, you know, physician-led ACOs. That would be an idea.

MS. DAFNY: And what we would say is, we would say this sort of initiative, which is part of the Gaynor proposal, more price transparency -- although I do have some concerns about the possibility that it can lead to collusion over prices -- can be beneficial. And we hope that that movement accelerates. We just don't want to wait that long in the hopes and not try to curb some of the serious abuses. This would address a lot of the

surprise billing problems, right?

MR. CHERNEW: Yeah, but there's other ways I can deal with surprise billing.

MS. DAFNY: You could.

MR. CHERNEW: Without out this. Right?

MS. DAFNY: You could. You could.

MR. CHANDRA: So the worry for me is just that

--

MS. DAFNY: Not that we are.

MR. CHANDRA: -- it's a big worry that like, look, you're being very modest and you're saying I'm going to use a multiple like 5 times the 20th percentile. To really give this teeth, most employers are going to say I'm going to use a multiple like two. Most legislators are still going to say I'm going to use a multiple like two. And then these quality effects become first order.

MS. DAFNY: You know, let's see it happen, right.

MR. CHERNEW: Well, and I would say in the surprise billing case, the reason why we hve not been able to get the good surprise billing legislation, in

part, is because people have made arguments like well, this top end, there is going to be some quality effect for whatever reason and therefore we can't go forward.

It's really a continuum of argumentation where first you have to decide whether you have to act. I think if we were having a discussion about the surprise billing you would say we have to do something and you could pick something that would lower the price in those places. And then someone could say well, there might be some quality effects -- maybe. I very, very, very, very, very much doubt it.

MR. CHANDRA: But this is a different problem, just to be clear, than surprise billing. This is very much a cesarean in San Francisco might cost --

MS. DAFNY: \$60,000.

MR. CHANDRA: -- \$60,000.

MS DAFNY: Right.

MR. CHANDRA: That's not surprise billing.

MR. CHERNEW: No, it's really -- it's really -

-

MS. DAFNY: You're saying (inaudible) really, really good (inaudible).

MR. CHERNEW: If the problem were just --

MR. CHANDRA: Or there's amenities that are really important to people, right.

MS. DAFNY: That's right. And we're saying there is --

MR. CHANDRA: And you're saying that amenities aren't important.

MS. DAFNY: No, I'm saying there's insufficient consumer agency to walk where you're willing pay for -- right -- combined with the moral hazard and the employer selecting the insurance plan, I might not want to have so many people going to (inaudible).

MR. CHANDRA: Or the employers are getting it right. They're acutely aware of what their employees want --

MS. DAFNY: There's empirical evidence that they are not getting it right.

MR. CHANDRA: -- and the employees want -- no, but employees may want access to these expensive places.

MS. DAFNY: Some might.

MR. CHANDRA: Exactly. So some might.

MS. DAFNY: Some might.

MR. CHANDRA: And they're willing to spend that. And other people are not, and so --

MS. DAFNY: When you get individuals on exchanges, you see they are not willing to trade (inaudible) over price.

MR. CHANDRA: Exactly. Because they are lower income. They're much lower income and they don't want to pay those very high prices.

MS. DAFNY: Again, if we were in a universe where we all got to pick our health plan, I probably wouldn't be here saying this. We just aren't.

MR. CHERNEW: I think the one thing I want to say about this discussion, which is important because we talked about c-sections in San Francisco, is there is a sense in which you might think from a comment like that, that well San Francisco is just very expensive.

MS. DAFNY: It is.

MR. CHERNEW: It is. The reason why our model is tied to the 20th percentile of prices in a market is the San Francisco effect -- if San Francisco were truly an expensive place, our cap would actually be higher.

And so we allow for some of that variation. It is true that when we lop off the top end of prices we are lopping off we are lopping off two things. We are lopping off a portion of market power, which we all agree should be lopped off, and we're lopping off a portion of what we might call valid, justifiable -- whatever variation in price. That's true, right.

I think I would argue that when you get to the range we're talking about, you're well above that sort of variation for producing a high quality c-section. But maybe I'm wrong in one way. Okay, I've been wrong about a lot of things in my life. But what I would say it's simply a risk I'm willing to take, given what else is going on in the system.

And so a lot really --

MS. APPLEBY: So let's talk about that cap, because a lot of employers, like Amitabh said, might look at that and say that's still a really high range. So why not tie it to a multiple of Medicare, perhaps as we saw in Montana, where the state employees' program went around and said, you know what, we're going to pay a little over two times Medicare, and they eventually,

with some arm twisting, got all the hospitals to sign on.

Your proposal would seem to be locking in at higher prices than that. So explain why you haven't based yours on Medicare.

MS. DAFNY: So, right, I mean we are -- as economists want to try to rely on our markets to work. Where they don't work we want to promote competition, we want to cut off this top end. We aren't proposing administered prices and tying our commercial prices to Medicare prices for a number of reasons. Then we have to rely on the Government to define the units of price, we have to rely on the relative prices. And it's well known that Medicare gets a lot of those wrong, if you will. And if we just set our caps, we still -- and they're based on commercial prices, we're allowing to some degree market forces to influence what those price are.

We also avoid exposing this regulation to all of the political issues surrounding Medicare. Because if Medicare prices formulaically cap commercial prices, now any debate over anything that happens in Medicare

becomes multiplied, leading potentially to even worse gridlock than we currently have.

MS. APPLEBY: Competition and whether or not competition is going to help constrain prices. Would this proposal be adopted sort of universally, or should it just be in markets where the market is not working? Anybody want to take on that question?

MS. DAFNY: I mean I'll take it on, if I might.

So the way that our proposal is designed -- we could have done something different. We could have said the 90th percentile price in every market, that's the maximum. That is not what we did. If you tried that proposal, you can see in our paper, it ends up saving just a little bit less than what we do, okay. But we didn't do that, we don't say that all markets must necessarily have prices are strongly indicative of market failure.

What we say is because the 20th percentile of prices is not nearly as spread out, there isn't as much variation in that as there is in say the 90th percentile, where you see some real extremes in lots of

markets, largely due to provider insurer market power, then we say if you are, you know, five time more than that, then we're going to say that is an outlier in terms of what's going on with your prices. We lop those.

So that would mean that in some markets you aren't affected. For example, we've done some simulations for inpatient facilities and services and outpatient. We find that the effect on outpatient physicians is much smaller because, guess what, there aren't nearly as many providers that are charging 5 times the 20th percentile in their market. So they would be less affected.

MR. CHANDRA: What do you do about markets -- rural markets where you don't have the price variation, but you have a large system? So you don't have the 20th percentile.

MS. DAFNY: That's right.

MR. CHANDRA: There's essentially one payer. That payer has some monopoly power. Now we want to think -- see, now someone like me can get into regulation, but I still wouldn't be using this kind of

multiple regulation.

MS. DAFNY: Mike has answer for you.

MR. CHANDRA: I would want to do just old fashioned cost based regulation, right.

MS. DAFNY: Mm-hmm, mm-hmm.

MR. CHANDRA: So why aren't you proposing cost based regulation for those markets?

MR. CHERNEW: We're proposing, to economist friends, were proposing something that's closer to a yardstick version of competition, maybe not exactly, where in situations like that you would look at the 20th percentile in other markets and use that as a cap for what could be charged there.

I think there are several other nuances we could talk about, about ways our proposal might be modified in order to deal with some of the lumpiness issues. Amitabh was nice enough not to talk about some of the data noise issues that make this also harder, so I probably shouldn't have raised it.

MR. CHANDRA: But what you just said -

MR. CHERNEW: But that's how we do it --

MR. CHANDRA: Michael, might be sort of a

middle ground where you start with the yardstick competition model, where you don't have this price dispersion, so rural markets, where there's just one sort of behemoth provider and everyone is beholden to that provider. Now we want to think about regulating prices at that provider. All the worries about attaching that provider's prices to Medicare come in and you could do things like we're going to rate regulate you at 20 percent, because there the argument that I'm making around gee, it's quality and people want to pay for the extra quality, is less likely to be true.

MR. CHERNEW: That's true, except I think the problem becomes some of those places have smaller volume, there's economy of scale and production. You have to worry about that. It's not that I think we fundamentally would disagree.

I think the bigger problem is because of a number of things related to search -- and, again, if you look at the work that Zach Cooper and I and some others have done and shows how bad the actual shopping process is -- you will find markets that look structurally competitive from an FTC kind of way in terms of our

measures of competition that have some really extreme outliers in terms of where the prices are.

And so the core question I think for people listening to ask themselves is, do you think that those extremes, those high multiples of any unit price of the market reflect market power from those providers or reflect a legitimate interest from employers or their workers to get amenities, or a whole bunch of other things at those places. And if we were to address those high prices, as happens in things like reference pricing, where do we see a commensurate reduction in quality.

I think all the evidence suggests if you can target people to allow them to choose -- even high income people in the reference pricing case -- you will see them move to other places and you will not see that quality will drop, at least not in a strongly measureable way.

MS. APPLEBY: So those are a really good point.

So let me get to a couple of the audience questions.

Somebody wrote in how, if at all, would the problem you're trying to address in your proposal be different under a Medicare for all type system?

MS. DAFNY: Very. I'll be brief. Medicare for all, right, would imply that anyone would have their providers paid at publicly administered rates, okay, which is not using the market to determine those rates. It is the case that a share of individuals are in Medicare Advantage plans where there is private negotiation of rates, and those rates tend to be pretty similar to what the publicly administered rates are. So we would be shifting away from relying on markets to rely on what the government says should be the price for things.

MR. CHERNEW: But our proposal is loosely what's in your local market times five, a Medicare proposal for say outpatient facility stuff is more like the market rates times .8 or something like that.

MS. DAFNY: The 20th percentile.

MR. CHERNEW: The 20th percentile times -- so it's much -- the price will be much, much lower, much less room for any of the things that Amitabh is talking

about.

MS. APPLEBY: Let's bring this down to consumers. So how would your proposal affect them? I mean are folks going to -- I mean if people are having a c-section in San Francisco, are they going to see their cost go down under your proposal? How would this translate into what consumers pay?

MS. DAFNY: A couple of things, Julie. So the out of pocket spend for consumers in the last four years has increased almost 15 percent. Now, part of that is due to the rise in deductibles. A lot of this is going to be at the high end, for hospitals certainly, where we're not going to see a change.

But certainly for some services, especially really, you know, certain professional charges that are exceedingly high, patients have high deductibles or have co-insurance, they're going to see a benefit and they ought to see their premiums -- or I should say premium growth come down, because realistically an actual decline, that's hard to do. And I expect that there would be a transition period for this proposal.

MR. CHERNEW: There's about an 8-10 percent

savings off the top. I think the bigger effect for consumers is when there's less financial pressure on the premium, there's less pressure for employers to raise those deductibles and do a whole bunch of other things than they're otherwise doing.

MR. CHANDRA: But in your response, Leemore, the assumption is -- maybe I'm getting this wrong -- but the assumption seems to be that because we've reduced healthcare spending, consumers are better off. And I guess the ongoing --

MS. DAFNY: No, I said consumers pay less out of pocket.

MR. CHANDRA: They pay less out of pocket, and that's desirable. And what I'm saying is what we're giving up is quality, including non clinical quality, which is valuable to patients.

MS. DAFNY: When has it been established -- I'm asking you -- that a cut in the highest prices leads to diminished quality. On the contrary, the highest prices increasing is not associated with any quality improvements.

MR. CHANDRA: But people --

MS. DAFNY: I grant you that there's a cross sectional relationship, I just wouldn't want to rely on that nearly as much on the data that we have about price growth not (inaudible).

MR. CHANDRA: We have the transactions of millions of patients --

MS. DAFNY: Yes.

MR. CHANDRA: -- high income patients, choosing these facilities, right. They choose to go to these facilities. Employers choose to allow their employees to go to these facilities. I read a lot into that. I think people are willing to give up income -- you said it's out of pocket --

MS. DAFNY: I mean so I feel that in a way -- we start our proposal with the statement of a problem. We think this is a problem. You don't.

MR. CHANDRA: Yeah, I think it's much less of a problem. I think the only time it's a problem is when people don't have choice and they're forced to go to the high priced facility.

MS. DAFNY: What if I --

MR. CHANDRA: That's what I think of as a

problem.

MS. DAFNY: So I'm in a health plan pooled with lots of people who want those choices. I have high premiums. And all of my enrollees -- so many of my colleagues are going to these high cost of care sites and I have high premiums. I can't do anything about it.

MR. CHANDRA: Right. So we should create a plan for that person to go to other facilities, not whack the -- it's sort of like saying, you know, because some people choose to drive, you know, I'm going to have no Uber Black because you're all fine with Uber X. Why don't we just have Uber X for people who want Uber X? And the people who want to pay extra prices and take Uber Black, they can take Uber Black.

MR. CHERNEW: If the market was nearly as

MS. APPLEBY: And I think

MR. CHERNEW: -- go ahead, Julie, I'm sorry.

MS. APPLEBY: I'm sorry. No, you know what, this has been a great and robust discussion and I think the points you just made, unfortunately we're going to have to leave it there because we are going to be moving on to our next panel on our next presentation.

But this has been really great. We've covered a lot of things. I think your paper -- and other folks can read them on line.

And we're going to turn next to a research presentation by David Cutler. So we're going to do that. So I want to thank the audience for participating and for sending in questions. And I continue to encourage you to do so as the afternoon moves on.

Thank you.

MR. CHERNEW: Thank you.

MS. DAFNY: Thank you.

MR. CHANDRA: Thank you very much.

MR. CUTLER: Oh, great. Well, let me say thank you to The Hamilton Project for inviting me both to present here, but more importantly to write this paper that we're releasing.

Let me give you a bit about what is involved - - what the paper says, and why I did it. As we were hearing both in the introduction to the overall webcast and in the previous panel, the urgent need to reduce spending on medical care is something that keeps building. And one of the things about many of the

solutions is that they address the price of health care, but in addition to that you need to address the underlying cost structure of health care.

So you have to be able to say both: I want to reduce what consumers pay, but then also because what consumers pay goes down -- filters down to the providers. What it is the providers have to spend to run the business, to run health care. And so reducing that is actually the subject of this paper, and in particular, the biggest difference between the U.S. and other countries in the cost of providing medical services is actually the administrative cost of health care.

So, all the billing, and insurance, and claims, and all of that is part of the administrative structure that adds into the spending quite a lot. So what I focus on in this paper is how we can go about reducing the administrative costs of health care in the U.S.

So let me just start off with some of the basic facts about administrative costs. The administrative cost, the estimates of the administrative

cost of health care vary a lot depending both on what one counts as an administration, and on what denominator one's looking at, the total costs and the denominator.

The estimate here is about 20 percent of U.S. health care though, and that's obviously somewhat uncertain, there are different types of administrative costs, and I'm going to focus on a couple of different dimensions of them. First, there are some administrative costs in private payers, that's the one that people think of a lot. Those are things like billing and marketing, and claims authorization, and managing payments, and so on.

But actually there's a larger amount of money in provider offices, hospitals, physicians and clinics and other providers who have to address the issues associated with health care administration. Both of them are important, but a fair number of the issues here are going to focus on those that are in the provider costs, and not just in the insurance end.

There are different types of administrative expenses, the most common, or the biggest group is what are called billing and insurance-related expenses.

Those are things like, filing claims, managing the claims process, submitting bills back and forth, going through the prior authorizations and so on.

And then there are non-BIR, non-billing and insurance-related expenses, general business expenses, HR and overhead, and legal, and all sorts of things like that. I'm not going to make too big a distinction because I think some things would cut across both. But there is a key distinction that I do want to make, which is between what I'd call between expenses that is administrative costs that are only going to be reduced when we get both sides of the transaction, both sides of the market to change. And then what I call routine expenses which are entirely internal operations.

So an example of the between expense would be claims management. That is a provider has to file multiple different forms with each different insurer, the form may be the same but what goes in the form is different, and thus there's the people who have to be particularly attuned to what goes into the form for one payer, versus what goes into the form for another payer. That's one type of between expense, where if one

standardized those one wouldn't have to deal with that.

There are also things about prior authorization, where again it's the fact that it's the insured -- the payer dealing with the provider that's the source of the cost. And so that's probably about a \$150 billion or so of spending on those between expenses. I've given the three biggest ones here, claims management, the claims processing cycle, prior authorization, and quality measurement, and reporting; that's keeping track of all the various quality information, and reporting it, and so on.

Underlying all of those is data interoperability. That is, we spend a lot of money doing things manually because we don't have the data where you need to do electronically, to do it interoperably.

So I'm going to discuss those four. I'm going to leave aside these issues of sort of within expenses, which is the C-Suite as the legal team, and so on, far too big. My sense is that proposals that successfully address the between expenses will also address the within expenses, but I actually haven't even estimated

any savings from that. So I'm going to tell you about savings that could be on the order 50- \$60 billion a year from administrative cost savings, a lot of money. But I'm going to leave out of the within specific types of expenses.

So where are we in health care? Let me just start with where the landscape is. We have pushed to have many things electronic, and public policy has, to its credit, done a good job pushing this, going all the way back to the HIPPA legislation in the 1990s, up through the Affordable Care Act, and in the 21st Century cures, and so on, in recent legislation. So we've pushed a number of things. So many things are now fully electronic, that its claim submission is electronic, for example, and coordination of benefits is electronic.

Some things are partially electronic, and other things are not particularly chronic at all, the most important of those are things down at the bottom of the chart, prior authorization which is still largely handled by phone and by fax, and claims attachments, so something that has to be attached to the claim so that the payer will pay it.

So obviously those things at the bottom are big concerns because we're using people where other industries use computers, and computers for these routine transactions are much cheaper than are people. In fact, in fact they're more secure and higher quality as well.

Even the top parts though are actually more expensive than they need to be, and the reason is that while the form goes from the payer to -- from the provider to the payer electronically, and then another form gets sent back electronically, the preparation of that involves an enormous amount of manual work.

And so if you compare, for example, health care to banking which is one of the examples that I talked about in the paper. In the banking system there's very little individual personal involvement, involvement of people in the transmission of money between one bank and another, where there's still an enormous amount of people involved there. So we're starting from an okay base, as we had some success in the past but nowhere near as much success as we would like.

So what is the government doing here? There are really three rationales which lead to the types of changes that are going to be needed. One is there's a sort of public good, which is that no organization will invest in coordination on its own. In fact, it's actually even worse than that, which is that organizations have incentives to not coordinate with each other, because then the data can't be shifted from one provider to another, one electronic medical record to another.

And therefore you have a situation where payers will -- and more vendors, and providers, and health systems will actually pay money to make their data not be available. That's really terrible, that's happened in a number of other industries, and every time the government has to come in and say, no, you can't do that. And so we're going to need the same thing here in administrative costs.

The government is going to have to be involved for other reasons as well, and it's also a big payer, obviously the Federal Government is a huge payer for medical care, and so nothing can happen without the

Federal Government being involved. But there's also a point down there which is that the price ain't right, and one of the things about administrative costs is that in general they're not paid for on a piece-rate basis.

That is an a payer that thinks about, for example, should I eliminate prior authorization requirements for a particular medication, or for a particular procedure, that provider will realize savings from its own internal operations, but it doesn't pay less because it's imposed less of a burden on the provider. So it doesn't achieve -- doesn't realize any of the savings from lower spending elsewhere in the system.

That's really a problem here because that's then suggests that they don't have sufficient incentives to get rid of things, or conversely, they're not seeing the full cost of adding additional complexity to the system. So one of the key proposals that I make here, in addition to standardization, I'll tell you how the proposals play out in just one side.

But one of the key issues here, in addition to standardization is going to be to try and implement a

set of prices, where it's clear to payers and providers how much administrative transactions, how much administrative costs account for, for each claim, and then say this is something that has to be paid for creating it. Unless that's going to give an incentive to say, I don't need to create that if I don't -- if it's not worth doing so.

So the broadly speaking, what the proposals involve is standardization, that is using electronic tools to substitute for individuals, and that's by standardizing, and second is making complexity be priced, and so those prices can then signal when we have too much of it.

So let me talk about some of the specifics, and I want to do it in terms of the four areas that I highlighted earlier, and the first is claims processing.

The most obvious analog to claims processing in health care is the flow of money in banking. In banking there are actually two parts to the flow of money. First there's setting standards, that is there's an organization which sets standards for what must be in submissions that banks send in, and second there's

actual transfers that go between banks.

So if you tell your bank to pay money to a company, your bank says okay, I want to take money from this account, and I want to send it over to this Bank in this account, for who is to receive the money. And so in the middle is the organization that does those transfers. It's actually a very cheap system. It costs probably about \$300 million a year to transfer about \$53 trillion a year.

So it's extremely cheap, all banks have to do this because the Federal Reserve says, if you want to transfer money you have to follow these rules. The idea in health care is to basically try and recreate this, because currently each receiving institution requires different things in different ways.

Again even the form is the same, but about what goes into it is very different. So the question is how to set up something like that in health care, and that's really what's proposed here, which is to say that there will be a clearinghouse, there would be two organizations. First there's the clearinghouse which would transfer things back and forth, and second,

there's a standard setting organization.

We actually already have a standard setting organization in health care, that's how those transactions have become standardized so far, so that already exists. What would be needed would be the organization that then says, this is how we're going to transfer it.

In the case of banking that's sort of required, you could either do the required version in health care. That is, you could say, this is the only way you can transmit information. What would I have here? Is you say, well, no, you can do it outside of that. As a payer you can request or require something outside of that, but you have to pay for it in the way we were talking about, if you create additional administrative complexity you have to pay for it.

The cost of running this system, if it's like banking, would be roughly \$300 million or so, there would also be one-time costs of a bigger amount for computer updates in both private insurers, and in public insurance plans, particularly Medicare, Medicaid. I don't have an estimate of that, but the potential

savings would be enormous, on the order of maybe \$20 billion or so a year, and remember those are largely one-time costs.

So it's not an issue of, would it be worth doing, it's really an issue of coming up with the money in the short term, because we know that the savings are happening in the long term, and we do have examples of that as I was talking about in other industries. So that's the first big thing is that the clearinghouse for transactions to enforce standardization.

The second thing I'm going to talk about is prior authorization reform, and this is fewer dollars but it's enormously frustrating. All providers say that this is the thing that bothers them the most about health care administration, it's leading to burnout, it's leading providers to leave practice, and a number of other things, patient frustration as well, because patients have to deal with it.

There's been a group of organizations that have come together and say we want to do some prior authorization reforms, so far that hasn't happened to a great extent, although there's potential for more and

good things to be done. What I point out in the paper is that first there are several existing rules that we know about that we can put in place, encourage more use of, and by encourage more use of, what I really mean is the government should help to spur the adoption of things like that.

So the most common thing that one hears about, that one wonders about are things like gold cards where providers who have done a good job in the past, or who have installed computer systems on top of their EMR system, to say yes this is approved by certain guidelines, then don't need to get additional approval from the insurer because the insurer can use the attestation of the guidelines that it's appropriate.

Things like that are really quite available, and they could be done right away, it's just there hadn't been pushing for them. In part there hasn't been pushing for them because no one actually has to pay the cost to the provider for each prior authorization claim. So I'm going to come back to that part again. The cost is estimated to be about \$12 per claim, and the payer doesn't have to pay money when they opposed that \$12

cost.

And so a big part of this is making that cost be there, in which case both the payer and the provider will then say, yes, if we can develop other alternatives like not questioning every case, and using gold card procedures, and so on, then that's going to be financially worthwhile to us.

So it's setting in place both what is the best practice now, and also building in an economic justification for the best practice to be the chosen one, has got to be enormously important because the typical physician who does any prior authorization, obviously things like pathologists tend not to, handles up quite a large number, about 30 per week.

Similarly, in the case of quality metrics we have again a situation where there's a cacophony rather than a symphony, so we have many different parts of the orchestra and they're all playing different things, a decade ago it was pointed out that Medicare had about 1,200 quality metrics and it was hoped that it would be reduced. Alas, in the last decade it's roughly doubled, so Medicare now has over 2,000 different quality metrics

for its various programs.

State and regional organizations have another 1,000-plus, if you look just among a subset of insurers you get hundreds more quality metrics. Everything we know about quality metrics is that in order for them to be successful they need to be meaningful, that is they pick up true dimensions of quality, they need to be harmonized, and they need to be based on electronic medical records, not in-patient reports, not just on claims information.

We have examples of where this can be done. For example, Minnesota is requiring insurers to submit - - to utilize the common information that comes in. It seems to be doing well, the administrative costs in Minnesota, I don't know if it's because of this or for other reasons, then when it's the study exactly on that, are low and actually falling as a share of total insurer spending.

So this sort of harmonization is sort of along the lines of what we're talking about, and again one can think about the cost part of this, which is making there be a payment associated with making things more complex

than they ought to be.

The final issue, of the substantive issues is that health care lags in the electronic data interchange. So on the left is sort of what typically happens in businesses where you can now access things electronically, I found of the equivalent of the electronic access in health care, there it is on the right, which is the individual and the fax machine.

I think the only place in the world where fax machines are still common, is health care must be keeping the fax industry alive by itself. Or if someone said, if we want to kill the fax machine, we need to schedule a funeral, and that's what we should do, which is to take advantage of what's happening on the left, which is in the typical industries, and transport it to what's happening on the right.

In this case there are lots of used cases for it. There's both the provider-to-provider data sharing. Gosh, wouldn't it be nice to know, and things like outbreaks of disease where which patients have been tested positive or negative. But also for patients who want to consolidate their records, and insurers who may

be required to keep longitudinal records. All of those cases create an opportunity to do this, we actually have the tools because they show up in other industries, it's really now a question of applying them in exactly the same ways we were talking about.

I try in the paper to estimate the total amount of savings that would come from this. My guess is that conservatively savings could be on the order of 50 to \$75 billion a year. I say that conservatively because again I've dealt only with these sort of between areas, that is where it requires coordination amongst multiple parties to do. I haven't at all touched the sort of within parts, which I think are addressable and would be affected as well, but again I just wanted to be very conservative here.

That by itself would not bring us to the Canadian level of administrative costs. I don't think anything other than putting in an exact style of the Canadian system would do so. But it would get us a reasonable part of the way there, and that's a fair amount of money that could then be passed on to consumers, it's several thousand per -- close to a

\$1,000 per consumer per year in savings. That's absolutely something we ought to think about.

As with anything, there are questions. And so I'll just give you a couple of them here. Is single-payer the answer? Well, it might be, and I say might because it really depends enormously on how you do the single-payer system, it's not just as an on/off. There are actually choices, and that influences, but as I was saying, as I was saying here, it's not the only answer, and even a single payer, you'd have to address a lot of these things because companies now do have different EMR systems, and there are different payment rules, and all sorts of things like that that would have to be addressed.

Will jobs be lost? I think the answer to that is yes, and that's part of health care reform, that is, health care should not be a jobs program, it should be something to deliver people medical care, and if we don't need administrative folks, then we shouldn't be hiring them in health care. There are many other things that people can do.

It will require upfront costs. I don't think

they're big amounts of money, we have thankfully spent the biggest amount of money on the electronic medical records, now what we need to do is say okay, now that we've invested in those, how do we take advantage of them, not just for storing information, not just for some communication across the -- across the system, but to use them to drive down on administrative costs, as well as to improve the aspects of patient care.

So that's really where we are. I think we've done a lot of the heavy lifting, what we need to do now is to take advantage of that and drive towards getting these savings. I am optimistic that they can be done, and I hope that that this paper provides a foundation for doing so. So thank you very much.

MR. SHAMBAUGH: Good afternoon. Thanks for staying with us for this final panel which is: *How Can Increased Competition Reduce Health Care Costs?*

I'm Jay Shambaugh, Director of The Hamilton Project. And welcome to the stage here at Brookings.

We heard on an earlier panel a concern, that competition can't do enough or do everything, but it still has a big role, and that's what we'd like to talk

about today. The fact that hospitals, specialists, specialist physicians, insurers, all have market concentration above a level that is typically marked as high concentration, and primary care physicians are, in some sense, rising and moving close to that level as well.

There have been many mergers in the health care industry, many ways in which competition seems unable to act to work on price and quality, and so what we'd like to do now is talk about what we can do. And to do so we have a terrific panel to talk about that. I'll just introduce people quickly, and then we'll dive in.

So Martin Gaynor is the E.J. Barone University Professor of Economics and Public Policy at Carnegie Mellon, and a former Director of the Bureau of Economics at the FTC. And Marty authored a proposal for us at The Hamilton Project, and that's part of what we'll be talking about today.

Elizabeth Fowler, to his left, is the Executive Vice President at the Commonwealth Fund. She has a long history in health policy, including Global

Health Policy at Johnson & Johnson, a Special Assistant to the President for Health Policy and Economic Policy at the NEC. The Chief Health Council at Senate Finance as the Affordable Care Act was being written, and so a lot of different perspectives to share on health policy and competition in policy.

To her left, Noah Phillips is a Commissioner at the FTC, prior to that was a Lawyer and a Counsel to Senator Cornyn, so in a position at the FTC, can hopefully share a lot about what we could be doing.

And finally to my immediate left, is Paul Ginsburg. He's a colleague of mine here at Brookings. He is the director of the USC-Schaeffer Institute for Health Policy, and a Senior Fellow in Economic Studies, and Professor of Health Policy at USC. And he was the Founder and long-time President of the Center for Studying Health System Change.

So I'd like to start with you, Marty. And start just asking you to tell us a little bit about your concerns with competition in the health care sector, and the kind of policies you would like to see to address that?

MR. GAYNOR: Well, thanks Jay. And thanks to The Hamilton Project and the Brookings Institution for convening this panel and supporting these efforts.

So, as people may know we have a market-based health care system. And what that means is that the U.S. health care system is only going to work as well as the markets that underpin it. Unfortunately, these markets just don't work as well as they could or as they should, and we can see that, every time that we engage with the health care system, or just look at some simple facts.

We have high, and rising cost, very high prices, egregious business practices, surprise bills, supposedly not-for-profit community hospitals, use of debt collection to go after people garnishing their wages, poor quality of care, and a sluggish and unresponsive health care system. Outside of that we're doing great.

One of the reasons for these problems is that there's not enough competition in health care markets. We've seen over the past 20 to 30 years just huge amounts of consolidation in the health care system,

although I want to be clear, that's not the only thing to look at when figuring out how competitive markets are. But nonetheless, just over about 1,600 hospital mergers in the past 20-some-odd years, many, many markets in the United States are dominated by one huge health care system, like my own hometown of Pittsburgh, Pennsylvania, for example.

And that has a lot to do with this performance. What do we get from all this, these decades of consolidation? We haven't gotten better quality, we haven't gotten more coordinated care, we haven't gotten a more innovative, responsive health care system. What we've gotten are higher health care prices, and we have little else to show for it.

So I have a set of policies I'll call them at an umbrella set of policies, to help enhance, to enable and promote competition where it's possible, and to flexibly intervene where it's not.

So there're roughly three components to these policies. One, reduce or eliminate policy, some of these federal, some of these state that artificially encourage consolidation, or impede entry or competition.

Two, strengthen and entrust enforcement so that federal and state agencies can act effectively to prevent and remove harms to competition. Just one piece of information from 2010 to 2018 the number of merger filings with the DOJ and FTC went up by 57 percent.

Over that same nine-year period their budget adjusted for inflation fell by 12 percent, enforcement actions have stayed completely flat over this time period where we've had this huge merger wave. And mergers are only one piece of this puzzle.

And last, the third piece of these policies, create a new agency at the federal level, or agencies at the state level, responsible for monitoring and oversight of all health care markets, and that has to be backed up or supported by a national health care data warehouse to provide the information.

This is the information age after all, and information is part of our infrastructure, just like bridges, and railroads, and airports, that has to back that up and support it, just for monitoring and oversight, but also intervention, flexibility where necessary. And where there's little potential for

competition, markets that are dominated by a large entity, that little possibility of competition getting in or being enabled, then this agency would have the authority to intervene when and where necessary.

So those are the three components to try and make health care markets work better so that all Americans benefit, as opposed to now, in which there are just a small set of entities that are benefiting, and most individuals are being harmed.

MR. SHAMBAUGH: Great. Thanks, that's really helpful. Liz, I'd like to turn to you and just ask, from your perspective, what you think competition and competition policy could -- may be accomplished in this space? What could we do to make the health care sector work better?

MS. FOWLER: Sure and thanks a lot for the invitation to be here today. It's a little odd to be in an empty room in front of all you, but I'm really glad to be here, and appreciate the opportunity. I really appreciate also the excellent paper that Marty wrote, and a lot of the ideas that that he explored in the paper, and a lot of that work is consistent with some of

the work that the Commonwealth Fund is examining.

We're looking at competition in health care prices particularly for hospital services, we are looking at the role of pricing transparency, and the potential for states to become stronger actors in this space. So I think it's all very consistent.

You know, this panel is talking about competition, the previous panel talked about regulation, you know, we debate whether we should have a free market versus a government-run health care system. And the fact of the matter is we have the worst of both worlds.

We don't really have competition, as Marty points out, but we don't really have regulation either. We sort of end up with the most expensive system out of all possible combinations, and some of the work at the Commonwealth Fund is also looking at the results of that expense in terms of the growing underinsured, and the rising deductibles, and unaffordable cost-sharing.

In terms of the recommendations from the paper, if states and the Federal Government adopted and implemented these recommendations, I think we'd be well on our way to restoring competition in health care

markets. I was particularly pleased to see the recommendation on 340B. We talk a lot about 340B and I think -- but not in the context of competition, and the role that it's played in a lot of the consolidation, and in the hospital markets.

It's a market distortion, the benefit is split very unevenly across hospitals, and it generates a substantial stream of revenue for hospital systems that qualify. And I don't think that's what Congress intended. That wasn't the purpose of the program.

So, I was really pleased to see that. On the issue of network adequacy requirements, I agree this is something to take a look at, but I think another point to think about is that as we are increasingly focused on social determinants of health, and the role that transportation plays, and how it's often a barrier to seeking care and receiving care, I wonder whether it's possible to think about loosening -- as we are thinking about loosening any restrictions on network adequacy requirements, that we also think about subsidies to provide transportation to people who need it.

The additional funding for regulatory agencies

makes sense. I'm sure Noah appreciates that recommendation. These agencies have clearly been under-resourced for way too long. And I'm also interested in thinking more about the potential new agency that Marty had recommended, the Commonwealth Fund just put out a case study on the Massachusetts Health Policy Commission. And maybe we should also take a closer look at the Dutch Health Care Authority.

I didn't see a lot about price transparency, and I know this issue came up in the previous panel, and the role that price transparency could play in increased competition. I feel that we are putting the burden though on consumers, and when we talk about price transparency we're thinking that consumers and patients are going to make more choices or better choices if they had this information.

And I guess I personally think that we should think about pricing transparency as a tool for employers and payers in the system, and as a way for them to understand what they're paying versus what the public programs are paying.

And we're looking at price transparency. We

have a study underway that compares commercial rates to Medicare for example, we're looking at the role of all-payer claims databases, we support a Federal approach, and I think you did bring up that point as well to generate information that can inform the public, and also payers.

So those were my sort of initial responses but really pleased to be here. Thanks again.

MR. SHAMBAUGH: Great. Thanks. Noah, I'd like to turn to you. So we've heard some things about what we could be doing on competition in the health care space. I wonder if you could share a little bit about what we are doing already, in some sense, and what the FTC is doing in this area.

MR. PHILLIPS: Absolutely. And Jay, thanks so much for having me. It's a real honor to be here with the great folks on this panel. I always have to begin these things with the caveat that what I'm going to say is just my own opinion, and not necessarily the views of other Commissioners or the Commission as an institution. But it is wonderful to be here with you and with the Brookings Institution and The Hamilton Project.

So, I don't think there's any issue that so affects American consumers in terms of their worrying about costs, as health care. Everyone seems to recognize this, and I think it's a priority for all of us at the Agency. And I want to highlight today three things we're doing on the competition side of the house that I think have made an impact, and can continue to make an impact.

And I want to break them down into three buckets. So the first bucket is enforcement, enforcing the antitrust laws, the second bucket is advocacy, working to help other entities change the way their systems work. To some extent this maps on to some of the issues raised in Marty's paper, with respect to some of the impediments that state laws can impose.

The third is study, continuing to add to the project in which we're all engaged, trying to understand better how to the extent we have markets, or to the extent we have regulation, how they're functioning. So with respect to enforcement, it's been a really exciting past, let's say two years, we're building on important work that's been done before.

With respect to mergers and conduct both the FTC is very active, so on the merger side a couple of issues that I'll note. With respect to the provision of health care services, we just went to court in the last two weeks to stop a merger in Philadelphia of two big hospital chains. We're very actively following hospital mergers. As Marty notes, some of those don't get triggered by Hart-Scott-Rodino, but that doesn't mean we can't challenge transactions, and we're very active in that space, and I think you continue to see us be active.

That activity and the success we've had builds on a lot of work, learning, understanding the economic dynamics of the markets, and then learning how to convince judges to go along with our theories of anti-competitive harm.

On the United DaVita merger which was both a horizontal and a vertical merger of an insurer and health care providers in certain geographic markets, another example of enforcement on that side. Of course we look at pharmaceutical mergers, that's something we've always done, it's something we continue to do.

But I'll also note some merger enforcement that is sort of health care adjacent. So we used the Section II theory not long ago to suit a block of the merger of Illumina and PacBio, that's in gene sequencing, and that's a technology in the market that is going to be increasingly relevant to how health care is provided in the United States. We were concerned about a monopolist buying a nascent competitor, and intervened to stop that.

The other set of cases that I'd note. On the enforcement side are conduct cases. So these are not in the merger conducts but they're conduct in which companies are engaging that we feel distorts or perverts competition, and I'll pick out, there are a number of instances I could use. I'll pick out the Daraprim case involving Vierra (phonetic), so this is a sort of now notorious company involving Martin Shkreli, where they, with a patent -- a drug that was off-patent undertook a variety of strategies to prevent generics from coming to market.

And we, again, using a monopolization a Section II theory, we're in court on that right now.

They're pay-for-delay cases, there's a bunch of different -- the Surescripts case which involves health records, again using a Section II theory, we were concerned that Surescripts, the defendant, is engaged in a variety of kinds of conduct to prevent others from entering into the markets where it is a monopolist, eligibility routing. So there's a lot of really active work on the antitrust enforcement side, that's sort of bucket one.

Bucket number two, as I mentioned, is advocacy. We do a lot of work with state governments in particular, helping to bring down barriers to people who want to practice in the provision of health care, and to people who want to build new hospitals, and add beds, which can be really important. Right, entry is a really important way that the market deals with what can be the negative effects of consolidation.

And so I'll take as an example, we're very active in advocating to states on scope of work provisions. For instance allowing nurses, let's say, to do the maximum work for which they are trained, and not necessarily under the constant supervision of doctors.

In rural areas, and other areas where you have a supply problem, expanding the availability of health care workers, and what they can do can be really meaningful.

Another area that I'll identify is certificates of need, right, so these are state provisions that prevent the building of hospitals, and that's something that we're really concerned about, and we like to advocate to eliminate those barriers to entry as we have done in the past year.

And then the last thing that I mentioned was study. So the FTC is a great agency for a variety of reasons, but one of those reasons is we have special study powers our 6B (phonetic) authority, and we're constantly evaluating how we do things on the consumer protection, but importantly for purposes here, on the competition side.

So we're doing a study right now on COPA laws, right, which can operate to shield from antitrust scrutiny transactions that can have an anti-competitive effect. There are a variety of reasons that these things exist and why they're triggered, but we're interested in learning about the effects that they have,

and we've done a workshop on them, and we've seen some really negative effects.

So that's an example of something that we're studying, and I think enforcement, advocacy, in particular to states, and continuing the ongoing study are some things that are being done today to help advance the cause of competition in health care markets.

MR. SHAMBAUGH: Thanks, that's a terrific kind of tour of what's going on now. Paul, I want to kind of finish this first round with you, and think about how much you think competition in antitrust policies really can do in the health care market. And in some sense, why haven't we seen more of it already over time?

MR. GINGSBURG: Sure, Jay. It's really a pleasure to be on your panel. For many, many years I've been working on this issue, what can public policy do to foster more competition and health care. A very enjoyable aspect of doing this, is that there's a lot of at least rhetorical support from both sides of the aisle for this direction. So it's been comfortable.

But now Marty has done a really good job of outlining the extensive range and policies that could be

pursued to make the health care system more competitive, and two conclusions of his really stood out to me. One was that many policies will be needed to be pursued to accomplish this, there isn't a single policy that will make health care more competitive.

And the second one is that even if all the policies are pursued there will still be markets already so consolidated that significant competition won't be possible.

But looking back over time I'm becoming increasingly concerned that while we have a pretty good idea of what the policy agenda to foster competition should be, very little of it has been pursued. I was excited ten years ago when Massachusetts passed legislation banning anti-tiering clauses in contracts between providers and insurers.

But as far as I know no other state legislatures to follow this although there have been a few recent agreements between state attorneys general and providers that they had challenged. A recent update of an earlier analysis of state laws to foster competition, like, catalyst for payment reform, found

very limited progress.

A key component of the competitive strategy is more vigorous antitrust enforcement, especially going beyond horizontal mergers to challenge more recent developments such as vertical mergers. But Marty has documented the sharp decline in Federal resources adjusted for inflation, for antitrust enforcement it was really shocking to me, and of course the health care system continues to race ahead in becoming more consolidated and less competitive.

Now, realistically health care stakeholders do not want a more competitive health care system and they will forcefully resist many of the policies that would foster more competition. So, policymakers who have supported this approach and concept will have to take some tough votes to turn it into law. A key component of a strategy for a more competitive health care system, is capping the tax subsidies to employer-sponsored health insurance.

But Congress recently repealed the Cadillac Tax version of this policy with large bipartisan majorities, despite its enormous impacts on the Federal

deficit. We know that competitive tools such as narrower-tiered networks rarely appear in employer-sponsored insurance, where lavish health benefits are still seen as a key tool for recruitment and retention.

A key test of how serious Congress is about fostering competition will come over the next two to three months. Important provisions that would foster competition are included in versions of the legislations to address surprise medical billing have been reported by the Senate HELP Committee and the House Energy and Commerce Committee, and whether those provisions are included in the final legislation, if there is final legislation, will tell us a lot about how committed policymakers are to this approach.

So I'm concerned about the prospect of many more years of talking about fostering competition without getting much done. To me it's time to be thinking more about regulatory approaches, I believe it's possible to design regulatory approaches that are compatible with competition, such as focusing rate constraints on the outlier providers, and keeping regulatory approaches simple.

The Daphne (phonetic) and (inaudible) paper really are an example of that type of thinking. So pursuing regulation does not mean abandoning the strategy of fostering competition, but I'm less willing than before to bet all of our resources on a competitive approach.

MR. SHAMBAUGH: Thanks. That's kind of a great segue. We've heard, you know, what we can do, what we are doing, and in some sense what we're not doing enough on. And I want to pick up on this last point you made and kind of pitch this to everyone, which is, as we're thinking about all the things we could do with competition policy, are there also spots where we just say, and we're going to need a regulatory approach as well.

And so Marty, in some sense you nod that way in the proposal itself, by having this kind of new agency that's in charge. And so I just want to hear a little bit from people on how much they think the competition policy goals could accomplish, and how much you really do feel the need to bring in a regulatory aspect.

MR. GAYNOR: Thanks Paul, for bringing this up. You know, there are lots of different facets to this, but one thing, I think it's not regulation or competition, it's regulation and competition. Markets need a certain amount of government oversight in order to work, even if it's pretty minimal, just setting the rules of the road, and that's regulation.

Sometimes they need more active intervention. So what I propose is again enable and promote competition where it can happen, but there are some places where it's just not going to happen, at least not in any reasonable amount of time, and there let's have a flexible approach to regulatory oversight.

Not simply price cap regulation, which can be fine in some circumstances, but I think something that provides a lot more flexibility, and also is not necessarily permanent, so if circumstances change, that competition is possible then we don't have regulation just embedded in place, that's one.

As far as politics, and look, I'm no political analyst, I'm not a political scientist, I'm not an advocate, and I'm just a simple person, and I don't have

a lobbying budget.

But Paul is right. This is not the first time by any means that some or all of us have been on a stage talking about policies towards health care markets. We've been doing this for a long time and we've seen some progress but not nearly enough. I agree with Paul on that.

It's not obvious to me that moving towards a regulatory approach is any easier politically than is competition. It does have some appeal if you just say, okay, here's one thing, price cap regulation, then at least superficially it looks like it's just one thing, and it looks simpler where I agree if you read my proposal, and I hope people will take a look. There's a lot of different moving parts, although I feel one of those things would still help.

But I don't know that's saying, let's enact a price cap regulation isn't any easier -- it's an easier sell politically against powerful interests, than is, let's increase funding for the FTC, or let's create a new agency to monitor, and oversee health care markets. I'm just saying. I don't know but it's not -- it's not

obvious to me.

MR. SHAMBAUGH: Liz, can I come to you on the same kind of question, of how we think about competition versus regulation in this space?

MS. FOWLER: Well, it was an interesting point, and I think we also, when it comes to competition versus regulation, when it comes to drug pricing, I think there's an area where both sides of the aisle, to some extent, have sort of decided that pure competition is not going to bring down drug prices. That you have a natural monopoly under a patent system, we've decided we like that because it is a way to get new drugs, there's some gaming of some of those rules as we've pointed out.

But both sides of the aisle now are looking at whether we need to step in, and maybe look at capping some of the price increases, or even go straight to where the House has gone, which is negotiation and --

MR. GAYNOR: I've got one idea on that that's very simple that would get us a long way there.

MS. FOWLER: Yes.

MR. GAYNOR: Just allow Medicare to take cost of a treatment into account when making coverage

decisions. They're prohibited from doing that, if they could look at that with regard to drugs or anything else, then all of a sudden, even if you've got a monopoly you have a strong incentive to think about how much you're charging for that that drug or that treatment. But that's not one we're (crosstalk).

MS. FOWLER: Yes. But interesting and we should explore that a little more.

MR. GAYNOR: Yes.

MS. FOWLER: But back to the discussion. This is a point where we've decided that maybe pure competition isn't going to work to lower drug prices. To the point about how difficult this is to do politically, I think both arguments -- I mean both sides of this coin are difficult to get through Congress.

If you think about it today almost anything seems to be difficult to get through Congress, although now that we're faced with a potential pandemic and, you know, maybe there is -- maybe this is an opportunity to think about this question and what else we might be able to get done, you know, in this window.

But I will say, you know, the problem with

something like surprised billing is it's just losing, you've just got a loser. That it's easier to think about legislation when you can create sort of a maybe you win some you lose some, but it's not just that you're losing. So maybe there's an opportunity to open the door a little bit and think about health care pricing, and competition, and regulation a little bit more broadly, and a little bit more comprehensively.

And I think either in the context of some sort of, you know, bill to address some of the problems in our system that are coming to bear under the coronavirus maybe there's an opportunity. I think at some point Congress is going to have to look at Medicare solvency, and that that presents a potential vehicle, and an opportunity to look at some of these issues. So I wouldn't give up on it entirely.

MR. SHAMBAUGH: No. You obviously have a competition lens here, but I'm curious how, sitting at the FTC, when you're when you're struggling in some of these cases trying to figure out, how you can use competition policy if there are spots where you're thinking; you know, at the end of the day we're going to

need some help from the other side. We're going to need some regulatory action because our actions just aren't going to be sufficient.

MR. PHILLIPS: So let me sort of offer some general framing.

MR. SHAMBAUGH: Yes.

MR. PHILLIPS: And get a little closer to the question. The general framing, right is that, and I suspect everyone -- I hope everyone would agree with this is, you know, all things equal you hope, you know, wonderful world markets do a lot of work, and the competition that the market provides helps to achieve whatever quality benefits, or lower prices that you would hope would exist.

The Antitrust serves a role to try to kind of on a targeted level correct some of the things that can happen whether it be a merger or series -- a set of conduct that impedes the market from working. But the underlying premise to the thing is that absent the merger, the conduct, what-have-you, the market would work. Where you have market failure, right, that's where regulation especially the less flexible kind about

which Marty is worried, that's where it has a greater role.

Health care markets, you've got a really weird amalgam, right, and we kind of have this world that we face, so I don't think we can approach it from the perspective of the kind of theoretical perfect. As an antitrust enforcer though, I think there are two things I want to add.

The first is that whatever the situation, whatever the set of laws that we've adopted, wherever Congress has gone or hasn't gone, we're going to look for how people are manipulating that process, we're going to look within the context of the law to root out problems.

So I'll throw out one example. We've got this appeal right now in the Fifth Circuit on a pay-for-delay case. That's a context where you've got the patent, right, you've got the monopoly, right. I think everyone agrees it's really important to support competition, but that doesn't mean there aren't things people will do that distort the competitive process. And that's always something, you know, at which we're going to look.

Then we had a recent case, I didn't highlight it earlier that dealt with product topics (phonetic). So this is another conduct in which parties engage within the confines of the system now we have, where we are worried about abuse, and where we think antitrust law can make an important difference.

But I do want to level that with a little bit of reality, and that is the following thing. Antitrust can't do everything, and there are a lot of people right now, if you read the editorial pages of these days, who really feel like antitrust can solve everything, and that look, it may be broad-wording or just their view of what antitrust law is, it's a general law against corporate power, or whatever, can and should do.

So let's take price regulation. There are people trying to use antitrust to accomplish price regulation. That's a worthy debate, but it's not a debate about antitrust law, it's a debate about regulation, and I want to live in (phonetic) this conversation, "live in" (phonetic) may be the wrong word, I want to add to this conversation --

MR. GAYNOR: You have a month or so in

(crosstalk).

MR. PHILLIPS: Thank you. Thanks you. Right, oh gosh, I need to clean my house. With some reality of what the law is intended to do and can realistically accomplish, and I do think putting too many eggs in that basket, is the wrong way to go.

MR. SHAMBAUGH: That's really great. Thanks. Paul, I know you, I think -- I had a sense you wanted to hop in when Marty was suggesting that, well, look, regulation would be really hard to do politically to, and such --

MR. GINGSBURG: Yes. I think there are two ways to think of why regulation might be easier to do politically, one is a matter of, you know, the stakeholders, what do they fear more regulation or competition? They may fear competition more, or that's what many economists would say.

The second thing is that, if you go back 12 years there was a long period of time when federal policymakers, cared about the deficits, and that often led to series of Omnibus packages of legislation to reduce the deficits, regulatory packages can save money,

both on the spending side and on the revenue side and then probably, you know, they're easier by the CBO than proposals to foster more competition.

So I think at some point we're going to have to be concerned about the deficit again, when we get there, Liz mentioned, the Medicare Trust Fund is running out of money, I think that's going to be somewhat of a game-changer in the potential of making regulation politically feasible.

MR. SHAMBAUGH: I want to just real quick to our audience. My team has passed out some questions that have come from Twitter, so if you're still tweeting while you watch please send more questions, we are using the hashtag HealthCcareCosts or to HamiltonProj. And Marty, do you want to talk back in now.

MR. GAYNOR: Just real quick. First I think Paul's point is really an intriguing one, and it will be interesting to see how it plays out. You know, if it can't go on forever it won't, although lack of attention to budgets and deficits seemingly has gone on a long time.

But I think both to the points that were made

earlier, even if we move to a price-regulated system, that doesn't mean competition is no longer an issue, and I'm sure -- I can't speak for Noah, but I'm sure Noah would acknowledge this that that the FTC and the DOJ are concerned not only with prices, but with quality, innovation, the whole realm of things that that matter in markets.

And we have a lot of evidence under administered prices, both in the U.S. Medicare system and abroad from the English NHS that where there's a potential for competition, quality is higher under a regulated price system, and where there's less potential quality is lower, and what we're talking about in the research studies, as this quality, is mortality.

So actually these are hospitals, both in the U.S. and in Great Britain, where these hospitals face less potential competition, people with certain kinds of health conditions were substantially more likely to die. And that's a really big deal.

MR. SHAMBAUGH: Yeah. So, I'd like to maybe do kind of rapid answers to some of these because actually there are some really interesting questions here, and so

really it's to anyone, so the first would be, one person points out, "This all sounds great to think about more competition, what about rural areas, where it's just going to be really hard to think about competition carrying the way if there's only one hospital, or a limited number of providers?"

And so I'm just curious how? You know, Marty, when you're writing the proposal how you think about that? Or really anyone, Noah, if you're thinking of doing enforcement what if there's just one firm?

MR. GAYNOR: Yeah. I think quickly, in some places competition just isn't possible, it's not just rural areas. By rural areas in particular, I think they have their own unique sense of issues, and they're very serious ones, the people who live in those areas are having hard times in many ways, not just with health care, and we have to think about how to address the issues that they face flexibly, and in a cost-effective way.

One quick thing to say about that is propping up a local hospital is in most cases likely not the best way to help the people that live in that area, but we

have to help them.

MS. FOWLER: To add one more thing, if you think about competition in rural areas just in terms of the hospital as a physical place to get care, and you're sort of ignoring other ways to get care like Telehealth for example, and that comes back to some of the issues you raised about scope of practice, and ability to provide services in a more flexible setting. So, if you just think about it in hospitals, maybe we need to think about it a little bit more broadly.

MR. SHAMBAUGH: Noah, anything to add?

MR. PHILLIPS: Yes. I agree with all of that, if you think about some of the advocacy we've been doing, it is about expanding the scope of work, right, in places that maybe the market is not going to dictate that there be a physician, or that the physician won't be available at the school, right, where you may need that physician. Having the ability of more people to provide for the need is really, really important.

We're going to scrutinize mergers that lead you to that one hospital in the area situation. You're going to hear horror stories on the other side, they're

going to be really tough equitable claims about, we need this, the hospital is failing, and so forth, and that's something that we encounter.

I should just throw this out, this is not an area of -- or this is an area where competition enforcement can make a huge difference, it's not going to be an area where I think we can do it alone, and I would really love to see, and you see this sometimes, a recent case in Philadelphia with the Pennsylvania State AG.

State AGs have a really important role to play here, they're a force multiplier. I sometimes worry when I read editorial pages, and I'm like all of the writers are concerned about competition in one part of the economy, and they're neglecting health care, and everyone wants to say, yeah, I'm bringing this case, I'm suing that guy, lots of less famous names, maybe even politically influential names, in a local area need a lot of scrutiny from antitrust.

So that's, I know, look, I think it's a really important area of concern and something on which we need to continue to focus.

MR. SHAMBAUGH: Good I want to pick up kind of on this same point, and then I have a different question for you, Paul, which is just. "Are there any benefits to hospital mergers?" I thought that was kind of an amusing question to come across. So, you know, we keep talking about these concerns, of these consolidating systems, and all that. What's the argument for letting any of them go through? There presumably is some reason that we think it's okay for them to merge, or is there really not at this point?

MR. GAYNOR: Well, a few things -- a few thoughts on that. One, hypothetically you think about it, well, how could hospital mergers improve matters. Well, they could save costs, right, they could eliminate or reduce unnecessary duplication, they could potentially increase care coordination, they could provide more resources to invest in certain kinds of things that could help out patients.

But now we've had decades of these mergers and we have a lot of evidence, and what do we see? We don't see consistent evidence that costs are lower, or quality is higher, or care is more coordinated, or that there's

more innovation in terms of organization and delivery of care. It doesn't mean there aren't some instances, but across the board we just don't see it. And now, like I said, we've had about 1,600 hospital mergers over the past 20 or 30 years. What are we waiting for? If the benefits are going to materialize when are they going to happen?

MR. SHAMBAUGH: So this is an interesting question, I don't know if it had occurred to me was: if we're thinking about a regulatory approach, and Paul, you've kind of talked about one. And Marty, you've got this kind of flexible oversight agency you talked about. How do we prevent it from just being a revolving door? Where it's health industry, people are kind of coming back and forth, and in and out, where it effectively gets captured. And so great, we've come up with this other way of trying to bring down costs but it just gets captured.

MR. GINGSBURG: Yes. I mean that's always going to be a challenge with regulation and, you know, there are situations, particularly say Medicare. You know, is Medicare captured? Do hospitals get all they

want from Medicare? Probably not, hence, because at least because of this Medicare issue they're competing with the rest of the government priorities, they're competing, you know, with whether we're going to need tax increases. But, you know, certificate of need, an example of where that does get captured, and that's what the research has suggested.

So it's definitely an issue, and it really going to have to be thought through, of designs that are less -- you know, there's a Maryland Commission, it regulates hospital rates, was designed in a way that had some distance, they had a lot of authority. Back in the 1970s when there was rate setting, they were tough rate setting programs, they weren't captured. Hospitals saw an opportunity to get rid of them once Medicare went to prospective payments. But anyway it's a great question.

MR. GAYNOR: Yeah. I think it's -- I think it's a tough issue and I think that when we think about any kind of regulatory oversight, even if it's relatively flexible and minimal, like I'm proposing, or it's across the board, we have to think about this. But one thing we were talking about earlier is that with the

massive deregulation that happened in the United States in 1970s and 1980s, with the exception at least a large part of the health care system.

We no longer have a lot of experience with regulation, and there's been some forgetting of all the problems we had with regulation. So if we're proposing to re-regulate or expand regulation, then we do have to think through carefully, and we should be looking back at some of the evidence we have from other industries when we had heavier regulation.

MR. GINGSBURG: You know, one thing I would suggest is that if the regulation is simple and transparent, I think that makes it harder to capture.

MR. GAYNOR: Yeah. Yeah. But I do think there has been some capture even in Medicare, right. How do physician prices get set, right? There's this commission that's dominated by certain specialties, that's one example of a certain amount of regulatory capture. So I think it's something that we need to pay attention to.

MR. SHAMBAUGH: So we've got just a couple minutes left, and I want to ask a couple questions for

our last two panelists on kind of more forward-looking things. And in particular this is something you had mentioned to me earlier that I was very struck by, is we're thinking about competition a lot, which kind of pushes you away from collaboration almost. And yet when we're thinking of value-based care, there's a lot of coordination required. And so how do we balance out kind of new models of care where you need a lot of coordination across players with competition?

MS. FOWLER: Well, you know, Noah and I were talking before the panel that we have a regulatory system that we need to revisit in a lot of ways, and update it and modernize. I mean you think about some of the Anti-Kickback rules that really prohibit arrangements, value-based and outcome-based payment arrangements. HIPAA for example might be protecting things that you don't want to protect, or maybe where you want more flexibility, but not protecting things that you think it's protecting.

So I think there's a chance and maybe an opportunity at some point to really revisit our regulatory structure which was built on a, as everyone

calls that, a fee-for-service chassis. And now we're expecting a lot more coordination and collaboration across providers, a different standard of care, a different way of doing things, and I think we don't have the system that's set up to do that. So I think we do need to go back and revisit some of these rules.

MR. SHAMBAUGH: Noah, the kind of last question on looking towards the future, one of the things that become more important in any industry, but health care also very much so, is data. And how is the FTC thinking about kind of the competition concerns that's around who has the data, who owns the data, how portable is the data, and things like that?

SPEAKER: Good question.

MR. PHILLIPS: We're taking a lot of that, right, and we're thinking deeply. Look, as the economy moves toward -- I mean, "toward" is probably already an outdated term for this, deeper into data where data are endemic, or use of data is endemic throughout the economy. We're always going to be looking at how the treatment of data operates within a given market, right, so we're interested in, is sitting on a bunch of data, a

barrier to entry, or contracts that deal with the dealing -- how you deal with data, barriers to entry.

The Surescripts case is actually a really interesting example where you've got health records moving between a variety of different parties, between the PBMs and the prescribers, between the prescribers and the pharmacies, and so on, and mechanisms that firms engage in to deal with data can have negative effects. And I was mentioning HIPAA before, right? HIPAA touches on a privacy issue, and people are very concerned these days about privacy.

But there are circumstances under which privacy and competition can be at loggerheads, right. Access to data creates a potential privacy issue, but it can also really enhance competition, and as we talk a lot about privacy, one concern that I have is that we overreact, and we try to tamp on down on what can be some of the most productive, competitive space, the sharing of records that can really empower patients, on speed, care.

I think of the context of either a patient who is sick, who is trying to see their -- you know, their

primary care provider and a bunch of specialists, and can't even get straight the same set of issues that they're facing, right. And maybe they're giving different information to different providers. That can be really bad.

Or, think about the context of a person dealing with an ailing and elderly parent where you have power of attorney and you've got to go through a whole bunch of bureaucratic stuff, just to get information from one person to another, that can't be good for patients, it can't be good for competition. And I think that's an area on which we ought to focus.

MR. SHAMBAUGH: That's great. I think we are out of time. This has been a terrific panel. I think it could go on for a long time. I'm very sorry those of you watching couldn't be in the room here with us, because I think it's been a great conversation, but I appreciate everyone watching.

And I very much appreciate Marty for authoring such a great proposal, and for everyone for being on the panel with us. So thanks very much.

MS. FOWLER: Thank you.

ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190

MR. GAYNOR: Thanks.

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ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190

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ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190