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WEBINAR

HEALTH CARE PRICE REGULATION AND PUBLIC OPTIONS: ASSESSING APPROACHES TO INCREASING THE PUBLIC ROLE

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P R O C E E D I N G S

MS. LINKE YOUNG: Hi everyone. I'm Christen Linke Young, a Fellow with the USC-Brookings Schaffer for Initiative for Health Policy. Thank you for joining us today for the second panel in our three-part series on healthcare prices.

Our series honors Uwe Reinhardt, the groundbreaking health economist who inspired many of us.

At our panel two weeks ago we discussed some of the evidence around healthcare prices. Digging into whether price are too high, and understanding the limits of our knowledge. Today we're focusing on policy tools that would expand the government's role in setting and regulating healthcare prices.

I'm joined today by four distinguished experts, and I'm going to briefly introduce them and then we'll get started.

First we'll hear from Bob Murray, the former executive director of the Maryland Health Services Cost Review Commission. Then we'll turn to Matt Fiedler, a fellow with the USC-Brookings Schaeffer Initiative for Health Policies. Followed by Cori Uccello, a senior health fellow with the American Academy of Actuaries. Our final panelist is Ben Ippolito, a Scholar at the American Enterprise Institute.

You can post questions for our panelists on Twitter, using the hashtag #healthcareprices, or email Events@Brookings.edu.

And now I'll turn things over to Bob to get us started.

MR. MURRAY: Okay. Thanks very much, Christen. I'll try to jump right into this as the screen comes up. The absence of federal activity to control private price growth in recent years, which has been a major concern for affordability for states, has really forced many states to focus on taking the lead and provide a rate regulation. If I could have the first slide.

And I'm going to focus on these four areas; price caps, insurer price growth limits, direct rate setting for both the private sector only as one option, and then also all payer rate settings is the last topic that I'll address. Next.

First, price caps. Talking about caps that would be applicable to both hospital and physician prices. And one advantage of these price caps is they can be less intrusive than setting rates directly because they can reduce the impact of market power of providers while at the same time allowing prices to fluctuate and be flexible beneath the cap.

I'm going to focus on two different categories. There's been a lot of discussion about surprise billing. But I'll focus on caps on out of network services and also caps on all services.

There are two key issues or questions about how to set caps and where to set them. In terms of how to set them, there have been discussions about benchmarking caps as a multiple of either Medicare prices, hospital costs, reported costs, or median inpatient or in network prices. And the pros and cons to each of those I'll maybe circle back to some of these later in the discussion.

The second key question is the pros and cons of how stringently to set the caps. If they're too loose obviously there's too much deference to the market, which is not functioning well currently, and the price caps will be potentially ineffective. If they're too stringent then there's potential for them to confer too much power to insurers. Next.

The first category I'll focus on is this issue of out of network caps. Out of network spending, although it only accounts for a small proportion of hospital spending, there's evidence that shows that a hospital, even one individual hospital, can derive substantial leverage over insurers by threatening to go out of network, and the health plan then must pay full charges for the remaining beneficiaries that are treated at the hospital. And the hospital charges can be in excess of 300 to 400 percent of costs.

Removing that threat has been shown to and capping out of network can restore negotiating leverage of the health plan relative to providers. We've seen this dynamic play out in the Medicare Advantage market where prohibitions on balance billing and the default to Medicare fee for service has greatly strengthened planned negotiating leverage such that prices closely approximately fee for service Medicare in the MA market.

Now various entities have tried to quantify savings, most recently Rand did an estimate of

capping out of network at 200 percent of Medicare might result in price reductions of 8 to 23 percent or savings of 23 to $81 billion in a given year.

The key issues associated with caps is how do you make sure that the payers, if they do get additional leverage, will restore that savings to subscribers and pass those on. The ways of doing that are obviously medical loss ratios would be one. Next.

If caps on out of network are not found to be effective, then we focus on caps on all services. And again, the issue there is where to set the benchmark for establishing these caps and how stringently to set them. Economist Mike Churnu (phonetic) in particular, has proposed setting a cap fairly high to avoid market disruption. He has a proposal to set a cap at five times 20th percentile in a region. Others have proposed caps that would be direct multiples of Medicare. So again, pros and cons to setting caps spread too stringently or too loosely.

I would say it's worthwhile to look at an approach adopted by West Virginia when they had a rate setting system where they established both a cap and a floor to try to protect hospitals that have lower prices and may be struggling financially. And hospitals and insurers then negotiated within that corridor to have some flexibility around market prices.

There are various savings estimates associated with that approach, but I think it's worthwhile to point out that not only one size fits all and that regulatory approaches can vary by region and limits can be adjusted. Next.

If the caps are not effective oftentimes providers with market power can, if a cap is set, raise their price up to the level of the cap. One state might look at providing limits on price growth. That would be either linked to something exogenous to the health industry, like the CPI or state gross domestic product growth. Again, these can be less disruptive and allow for negotiations. But they can also be tiered based on a provider's level of prices, as we'll see in one proposal. And again, there can be some regulatory flexibility.

Next I'll talk about the two approaches. One a very intriguing approach that was applied in the State of Rhode Island where insurers cannot accept contracts from hospitals with price increases

exceeding either the federal CPI plus a certain percentage. It started out as CPI plus 1, and lowered it to CPI later on. And that was shown by a recent study published in Health Affairs to reduce hospital spending fairly significantly in the period 2010 to 2016.

Now it's worthwhile noting that this type of approach doesn't address existing price variations although we've conceived of a way of also addressing price discrimination under an overall approach like this, that we can talk about later.

There also may be dynamics associated with the individual negotiating leverage of a plan in an area versus providers. It may work in an area like Providence, Rhode Island, it may be less successful in an area like Boston, for instance. But the key take away is that the use of administrative agency regulations offer states a viable option for controlling costs and potentially less potential for regulatory capture to occur because it's thought that maybe an insurance commissioner is less affected directly by providers relative to a regulatory agency that may be vulnerable to capture. Next.

The second option for limiting price growth was a proposal that Massachusetts floated in 2017. It would have left base private sector prices unaltered but limited the rates of growth of hospitals. It would have also been tiered based on each hospital's relative costliness, the highest prices getting lowest updates and vice versa. But the legislation was strongly opposed by the highest priced providers, not surprisingly, and was defeated.

And this points out again, I think an Achilles' heel of a lot of these regulatory approaches, which is that regulatory agencies or legislative initiates can be subject to regulatory capture or political interference. Next.

In terms of direct rate setting approaches, there are a couple of things to consider. One is setting a fixed rate per service. First I'll talk about the private sector. There's a good example in California in 2018. Assembly Bill 3087 would have set prices for all hospitals and physician services benchmarked for Medicare. That, unfortunately, was defeated by the hospital association out there. But that was a good example.

The benefits of an approach like this is it doesn't require the heavy lifting associated with

creating a rate-setting system from scratch within a state.

Another example are the three state employee health benefit plans where they propose benchmarking the Medicare. There's been a lot of literature about these initiatives in Montana, North Carolina, and Oregon. A variation of this approach would be the approach plan to be adopted by the Washington Public Option, which would have set aggregate carrier spending benchmarks in Medicare which gives carriers a little more flexibility. Next.

Finally, talk about conventional rate setting. It's worthwhile noting that while ERISA is very restrictive as it applies to self-funded plans, it doesn't preempt state laws that govern healthcare providers. So states like Maryland could implement an all-payer system or other states could implement a regulatory system directed at private sector payments.

State based rate setting, as many of you know, were very prevalent in the '70s and '80s. There were four all-payer systems, Maryland's the last system to remain. The performance is mixed, early on very, very strong cost containment performance. Those systems also improved payer equity financed on compensated care, and improved financial stability of hospitals.

There are a number of challenges. One, there's not been an all-payer physician payment system established in the United States, although they're common internationally. A system like this would require a Medicare/Medicaid waiver and a state would need very strong regulatory authority in the insurance statute, along with significant data collection and technical actuarial capabilities for their staffs.

So bottom line on all-payer rate setting, the conventional rate setting of this nature is it's a heavy lift for most states. And maybe if you could turn to the next slide.

An alternative would be a system of global budgets as Maryland has implemented. I would advocate focusing global budgets on rural or regional hospitals that served captive populations. They seem to be most effective in those types of geographic locations. They have significant advantages over conventional rate setting because as in the case of Maryland and also Upstate New York in the '80s and Rochester and the Finger Lakes, they were very effective in containing volume growth and overall cost growth for the hospitals.

They also have the advantage of being much more administratively simple to establish and implement. The global budgets derived from existing historical payments, a waiver would be required to allow a state to implement something like this, but once a global budget is established for public sector and private sector payments, a regulatory agency could update the rates over time and achieve some level of cost containment, as has occurred in Maryland, and as I said, in Upstate New York in the '80s.

It requires regulatory oversight and also flexibility to deal with unforeseen circumstances. And also I would recommend a supplemental pay for performance incentive to reduce the potential for providers to stint on quality of care.

So I'll stop there. I do have a couple additional slides and maybe if we have time we can circle back to them. And I'll turn it over to Matt.

MR. FIEDLER: I'm going to discuss approaches to reducing healthcare prices by creating a public option. To start, I want to be clear what about I mean by the term "public option." So I'm going to use the term "public option" to refer to a publically operated insurance plan that's offered for purchase alongside private plans.

I think for people who have been following the federal policy debate since the ACA and before, that's a very familiar definition. So I'll just note that the term has been used somewhat differently in the state context in recent years for further proposals that I think are in many respects more similar to some of the types of approaches that Bob just talked about than a sort of federal level of adoption.

So within the sort of broad category of this type of proposal there are a whole lot of design decisions and variations you could think about. And for the purposes of my remarks I'm going to focus on proposals where the public option sets prices administratively through processes sort of similar to Medicare that might be literally setting prices at some percentage of Medicare, say 110 percent of Medicare.

Where providers are required to accept public option patients and actually provide some meaningful level of access to the patients. They're not just promotionally participate in the public option and make it impossible to get an appointment, but actually provide meaningful access to services. And

where other than those two features, the public option is otherwise in sort of a level playing field with private plans that has to fund its cost at a premium, enrollees can use the same subsidies to enroll in public option that they can use to enroll in private plans subject to the same regulations around benefit requirements and the like, and participate in risk adjustment on a similar basis.

There's a whole lot of details that's underlined that, you know, set of level playing issues that I think Cori is going to talk about a little bit more. But suffice to say, that's sort of what I have in mind to share.

So how might this type of policy effect prices? I think you can think about two types of effects. One is presumably some people would enroll in the public option, and then providers would be paid at the public option prices for delivering care to those enrollees. So that's the sort of most straightforward effect.

But a public option could also have effect on the prices that private plans are paying healthcare providers. So if a public option were a strong competitor for private plans in the sense that it offered a lower premium than existing private plans or was more attractive in some other way than existing private plans, the landscape for negotiations between providers and private insurers would change pretty dramatically.

Private insurers, if it wanted to remain competitive, would have to offer a premium that's not too far above the public option. But that would mean that signing network agreements where that insurer was paying prices substantial above the public option prices would make the insurer unprofitable. So the insurer would now be willing, would rather walk away from the negotiating table than pay prices substantially above the public option.

The flip side is providers would recognize that if they refused to join the networks of private plans, many of their enrollees would probably enroll in the public option instead and the provider would be paid the public options rate. So providers are unlikely to be willing to accept rates that are too much below the public option prices.

So the bottom line in a situation where an insurer is not willing to pay too much more than

public option prices and provider is not going to pay too much less is that you'd expect the parties to negotiate rates that are somewhere close to what the public option is.

The implication of that is if the public option is paying less than existing private plans, then providers will take less in the public option than they are with the status quo. That would be the case on average in the scenario I'm thinking about. It might not be the case for every individual provider, it might be the case that for most providers they're paid less than the presence of the public option, but there are some specific providers where the public options rates are particularly generous, and those providers end up being paid more.

There is one corollary of the fact that a public option might have a substantial effect on the rates that private insurers negotiate is that it's far from a foregone conclusions that a public option would end up dominating an insurance market in which it was introduced even if the public option was paying prices far below what private plans are paying today, since private plan rate structures would presumably change in response to the introduction of the public option.

And that is consistent with what we have observed in Medicare Advantage, where private plans had a substantial and growing share of that market even as they compete with the quasi-public option in the form of traditional Medicare.

So the two mechanisms I'm talking about here about how a public option could affect prices, but this is a direct effect and the indirect effect only operate if the public option is a strong competitor for private plans. So if no one wants to enroll in the public option because it has higher premiums than the existing plans or unappealing for some other reason, it won't capture market shares so the direct effect won't happen. And if it doesn't have any market shares it's not going to put much competitive pressure on private plans to change the landscape for provider/insurer negotiations.

So what's going to determine in practice the public option is a strong public option. So, you know, sort of the most obvious factor is what level of prices the public option pays for providers. So if the public option is paying providers more than existing private plans, it's presumably going to have a higher premium, not many people will enroll in it, and be basically irrelevant to market outcomes.

Another factor to think about is, you know, the various non-priced deferments of the public options cost. So, you know, how effective it is to management utilization, to what extent does it experience adverse selection, how good is it at coding diagnosis for risk adjustment purposes, and what does its non-claim standing look like.

Experience from the Medicare Advantage context and elsewhere I think is reason to suspect that a public option may have some disadvantages along most of these dimensions, with the exception of non-claim spending where it might have somewhat lower spending. But that would somewhat weaken the public option, somewhat offset the public option's advantages in terms of price setting, and probably reduce both the market share it captures and its ability to discipline the prices paid by private plans. In extreme cases where the public option was clearly adversely selected, it might have little effect on market outcomes at all.

And then, you know, a final note is, you know, I've assumed so far that providers would be required to participate in the public option, but some proposals would make provider participation voluntary. You know, in that case if the public option tries to pay prices meaningfully below what existing private plans pay, the public options network could end up being extremely narrow. In which case it may not attract much enrollment and it may have little effect on prices either directly or indirectly.

So just to close out, you know, some quick thoughts on how to choose between public option and price cap approaches. For the moment I'm going to stipulate that we want to reduce provider prices and that we think truly competitive approaches are not going to go far enough towards that goal. I'm sympathetic to that view, but that's a hard question and obviously contestable.

But I think the first question in choosing between these types of approaches is what problem we're trying to solve. So if we're primarily targeting provider market power I think there are arguments that well designed price cap approaches are superior to a public option. It's easier to figure out how to target price caps to specific provider types or particularly points in price distribution, which is a bit tricky to do, it's impossible to do with a public option. It avoids the risk that you have under a public option, that is ability to check prices may be undermined by the various types of non-price costs it

manages we talked about on the last slide. And it avoids the operational complexity of standing up and running an insurance plan, which is not trivial.

That said if, you know, part of the policy motivation here is not just reducing the prices providers receive but also checking insurer market power, that's not something that provider price caps on norm do, and while you could think about other tools like law regulations and the like, I think there are some potential advantages to a public option as ways of checking insurer market power. I think that may be a particularly relevant argument in favor of a public option in the context of the individual markets.

The second question in choosing between the approaches is just which one is feasible. You know I'm not going to dive into that deeply here, and it's frankly not completely clear to me which direction the political feasibility consideration cuts. But this is a legitimate basis for policy decision, and as you know, any feasible policy doesn't do anybody any good, so that does need to be part of the calculus.

So with that, I will hand things off to Cori.

MS. UCCELLO: Okay. So I do not have any slides. So thank you, Matt. Matt outlined a couple of the key design issues in developing a public option. But as he alluded to, there are many more, and my role today is to walk through a few of them.

But before we get to that, I first want to say what a privilege it is to be participating in a webinar series honoring Uwe Reinhardt. Years ago when I was taking my actuarial exams I came across some of his work and it's what helped spark my interest in health policy.

A couple of panelists from the first webinar mentioned being part of the 2010 Medicare Technical Panel with Uwe. I, too, was on that panel and was thrilled to have the chance to work with him. He brought his usual wisdom and insights, along with his humor, to help us work through some fairly thorny issues. So thanks again for inviting me to participate today.

So now back to public option, the key design issues. Matt kind of mentioned this, but I'm going to say it again. As, you know, whenever I talk about a public option or any reform proposal, I want to emphasize that the goals of the proposal need to be clear. We need to know what problem we're trying to solve, where we're driving toward. Because the goals should really drive the design decisions.

So today we're talking about implementing a policy in the context of a goal of lowering prices. But of course a public option can have other goals such as increasing competition, expanding choice, or reducing the uninsured rate. And these of course are not mutually exclusive goals, but I think we need to keep these in mind as we're thinking through some of these design issues.

So a couple of the key design issues are where the public option would be offered and who would be eligible. If we're talking about a federal policy we typically assume that the public option would be offered everywhere. But it could be limited to particular states or areas, perhaps depending on the level of current insurer competition or prices.

In terms of eligibility, would eligibility be for individuals only or could employers also purchase the public option for their workers? Opening it up to employers would increase the number of people with access to the public plan, but it's not clear exactly how that would work. It could be somewhat straightforward to offer this for small groups, but more complicated for larger experience rated groups or self-funded employers.

Another question is whether there are specific individuals who would be newly eligible, such as those with incomes less than 100 percent of poverty in non-medicated expansion states.

And something else to determine is whether the public plan would be offered directly on the exchanges. And this ties back in part to whom the policy is targeting. For instance offering the plan on the exchanges could reduce the benchmark premium, which in turn could reduce premium subsidies. Now that would lower federal spending, but research from Rand and others suggests some subsidized enrollees would pay more.

In contrast, unsubsidized enrollees would be more likely to have lower premiums. So if reducing premiums among unsubsidized enrollees is a goal, then the public option could be offered only off of the exchange.

There are other ways around these different issues, but I just want to point out that these are things that we need to be considered.

Another key design issue is how it's administered. Would the public option be fully

administered through the federal government, such as through CMS, or would the insurance or the administrative functions be performed by other entities such as insurers? So this matters not only in terms of what entity is bearing the insurance risk, but also for other functions such as utilization management, which Matt noted, can affect whether the public option is a strong competitor.

So Matt mentioned this, a big issue for a public plan is whether it's going to be on a level playing field with the private plans. And I'm going to assume that that's the intention, but now what would that entail?

So first the public option would probably need to be part of the ACA single risk pool. So it would follow the same issue, rating, and benefit requirements as other ACA plans participating in the market. But it would need to be determined in which metal tiers the public plan would be offered and if there would be multiple plans per metal tier with different cost sharing configurations. So there would still be a lot of work to do in terms of figuring out what the plan design would be, what the cautionary features would be.

Now being part of the single risk pool means that the public plan would be part of the risk adjustment program, and I'll talk a bit more about that in a minute.

So another issue with there being a level playing field is that the public plan premiums would need to be set to cover claims plus administrative expenses. Private plans have to pay health insurer taxes and fees. So would those also apply to the public options? Would the public plan be required to meet capital and surplus requirements like the private plans do? And would the public plan have to meet medical loss ratio requirements?

Another design issue is whether the addition of a public plan would necessitate the adoption of additional risk mitigation mechanisms, at least initially.

So as a reminder, risk adjustment works in the ACA to shift funds from plans with healthier enrollees to plans with sicker enrollees. And this helps reduce plan incentives to avoid high cost people. Now presumably the public option would participate in the risk adjustment program and funds would be shifted among the plans depending on the relative risks of the public plan and the private plans.

But I want to be clear that risk adjustment does not mitigate the risk for the market as a whole being sicker than expected. So if there's concern that the entry of a public option would make premium pricing more difficult due to increased uncertainty, this is where something like risk corridors could come in. Risk corridors can be one-sided, protecting plans against unexpected losses, or two-sided to also protect against windfall gains.

Reinsurance is the third of the three Rs. Reinsurance reduces plan costs for insureds with high health costs. Now the ACA had a reinsurance program for the first three years. And now many states have reinsurance programs for 1332 waivers. Presumably any reinsurance programs would also apply to the public option.

And finally, I want to note that while it's important to think through the public option issues in isolation so that we can better understand the questions that need to be addressed and the possible implications of different decisions, it's also important to understand how a public option would interact with other potential provisions. For instance the creation of a public option could be paired with increases in premium subsidizes, with auto enrollment, with an elimination in the fire wall between employer coverage and eligibility for ACA subsidies.

So these types of provisions, either alone or in conjunction with a public option, could affect risk pools, premiums, and enrollment. So it's important to keep all that in mind.

So I will leave it there, and pass it to Ben.

MR. IPPOLITO: All right. Well the goal of my opening remarks is to try to outline why somebody might come to this discussion of rate regulation, both direct and indirect rate regulation, with maybe a little more skepticism perhaps for regulation of this type. And I wanted to point out that one I really like about this panel is that we're comparing public opinion and more direct rate regulation approaches for exactly the reason that Matt laid out. Which is that as soon as you do something that defines the outside option in the way that a strong public option would, you have this very direct, or as he calls it, this indirect channel where you do have this really meaningful effect on the equilibrium rates that you see in the rest of the market. Right?

And so I'm going to talk about things as for rate regulation today, but I very much think of these two things as being similar or roughly equivalent practically in that sense.

But I thought what I would do is start by laying out what I sort of think of as something of a conventional wisdom when people approach this idea. And it goes something like this, right? When you compare the U.S. to other countries, it really looks like our provider prices are too high. And given that we've had decades of the market sort of having an opportunity to control these costs and seeming to fail, it seems like well now the only way (audio skip) let the government come in and regulate the rates in a more direct way.

And so I wanted to kind of take that on in each part, and I really don't mean that to be that as sort of a straw man, I really do think this is kind of where a lot of people are on this topic.

But I'm going to start briefly with the basic premise, right, this idea that the prices are too high. Right? And what we care about when we get into these policy discussions is not necessarily just the level of variation of prices, but what those prices reflect. Right? Are these reflecting things that are valuable, in which case it's sort of fine. Or are these things that are reflecting very little value, in which case the argument for more aggressive interventions, be it rate regulation or other approaches, is quite a bit stronger.

All right. And so what I would argue very briefly is that I think that the causes of the pricing dynamics in the U.S. are really not as well understood as many would argue they are. So in particular, we spend a lot of time focusing on one source of what we tend to think is low value but high prices. Right? Consolidation. We've seen a lot of consolidation and it is obviously a clear issue. We see markets that have fewer, say, hospitals, tend to have higher prices, Marty Gaynor and others have shown that for example, monopoly hospitals tend to have rates that are 12 percent than hospital markets for competitors. Right? If that's not getting us value, I will take 12 percent lower prices all day and twice on Sundays.

But that's a really small share of the variation that we're trying to understand and we're trying to explain. Right? Indeed we see markets where we have providers that are otherwise reasonably

competitive, Boston often comes up but it's certainly not alone. Where we have these providers that are able to get really, really high prices.

And the reason that matters and the reason that's sort of not having a full picture really does matter, echoes something that Allen Antobin (phonetic) actually talked about in his presentation in the first panel of this series. Namely that we don't want to just whack down the prices that reflect actual value just because we can't measure the value. Right? So as he noted, our data sets when we study these issues of provider pricing, they don't come with lots of information about amenities and all sorts of quality measures. We can tell, you know, mortality, but that's about the extent of it, things of that nature. Right? We can't measure things like convenience and so on, right?

And so the point is not that you think that these prices are necessarily even sort of at the right level in the sense that these kind of things are worth it, but it changes the way we think about these kind of policy interventions in the sense that sometimes in perhaps a pure consolidation model, we don't have to worry too much about the kind of tradeoffs that we might have to worry about if these prices actually reflect some genuine value.

The second point I want to talk about is this idea that it's really the market's failure that's led to this sort of out of control costs, and certainly is evidenced by the fact that we're not talking about Medicare prices, we're talking about commercial market prices, right, and that's where we think that the market is left to run less free, I should say.

And I think that's giving it a little bit too little credit. So in particular we do see certain parts of the healthcare market work reasonably well, right? We see all sorts of things like tiered networks, reference pricing formularies, that seem to do reasonably good job, and it's always going to depend on the exact features and the designs and so on, of actually working towards improving the efficiency of our spending, right?

Generic usage is a great example, generic drug usage. There we have a case where there really is a very confident situation. We know there's no quality difference, right, but prices are very different. In those cases the market works pretty well, right? We have 93, 94, 95 percent generic

utilization, right? We also see hallmarks of pretty normal markets in other places, like providers that do have observably higher quality tend to gain more market share over time. That's a good thing, right? That kind of speaks to this idea that some of what we're seeing might be valued so we want to tread a little bit more carefully, right?

And in particular I think it's important to emphasize since we're talking today about what I think of as sort of ex-post rate regulation, right? We're looking at the market and saying gee, I think these prices are too high so I'm going to try and come in and really chop them down.

Well we're also talking about a market where the government's going to have its way on the front end to depress these normal market incentives to constrain costs. So for example it kind of a mirror image of the rate regulation approach is we do the opposite where we tax exempt, for example, all of your spending on health insurance in this market, which is going to depress these normal cost disciplines that we would otherwise see in this market.

And so you add those things together and I think a reasonable person can say well, certainly rate regulation is an option, there's no question about that, but it's not the only option, nor is it necessarily the most obvious choice, right? In part I think the argument for doing things like starting with, you know, revisiting some of these open-ended subsidies on the front end is that we know we don't know the whole picture of what's going on with these prices. And so what we can do is try and impose policy changes that both introduce more cost discipline on the market and give us a sort of an opportunity as researches to say what are people going to give up as the costs become more real, as the costs and benefits are really weighed in a more real sense. As Mike Churnu actually talked quite a bit about at a previous panel. And as he noted, the market really does shift quite rapidly when costs are actually born by people.

So I'll conclude by noting that, you know, as Bob mentioned, part of this, part of my personal view I should say, is informed by the fact that we do have a history at this, right? And history, I think, offers a number of cautionary lessons. In particular, this is not easy, this being rate regulation. So as he noted, we've seen a lot of states try regulation rate approaches in the past and we've seen real

efforts that are sort of derailed by things like political capture. Those of us who have spent time working on a small rate regulation issue of surprise medical billing, know that political interests have done a lot of work to inhibit that policy making process, right?

The State of Maryland where there is an all-payer rate regulation system looks a lot like a place where we might worry that hospitals have a lot of control over the rate regulation system. We've also seen historical evidence that, you know, states have trouble, you know, sort of responding to strategic responses that sort of continually come up in this sore of whackable game as we try to move these sort of rate regulations shell game around.

So that all being said, it's tough to do the rate regulation approach. And so I do think there's genuine merit for this more pro-competitive set of policies. And with that I guess I will turn it over to Christen.

MS. LINKE YOUNG: Great. Well that was a wonderful overview of the issue from all of you. Thank you so much. As a reminder to folks, you can ask questions on Twitter using the hashtag #healthcareplaces, or email us at Events@Brookings.edu.

So I want to start with a question that we've heard from a number of people in our audience that although a number of you mentioned in your remarks on the method of the politics.

The politics of any action in this area are hard. What thoughts do you all have about how to assemble a political coalition to make reform happen? And what concessions might we see in the policymaking process, and where do we risk those concessions potentially swallowing the entire policy?

So, Matt, I want to start with you, but I think a lot of folks are going to have interesting thoughts here.

MR. FIEDLER: I mean, you know, the first thing that I say is I don't think it's a coincidence that the last time we talked about a public option was 2010 in the context of passing a significant set if term expansions, and that we're again most of the time, certainly at the federal level, people were talking about public option are also envisioning some set of subsidy expansion to go along side it. And that's because the savings that potentially come from a public option can be used to finance

those other coverage or subsidy expansions.

And so I think, you know, that both directly provides a counterweight of people who are benefiting from the package of policies against the provider, it also means, you know, the providers also benefit directly from that coverage expansion, particularly the hospitals. And so that may make it sort of a little bit easier to take medicine from the provider's side.

You know, I think the other question, from my perspective, and I think this really influences the choice between for the public option approaches versus price cap approaches, is it is a pro or a con that a public option takes on both the providers and insurers?

On the one side you're now fighting on two fronts rather than one. The flip side that we've seen in subsidized billing contact is allegations that the, you know, efforts to address price billing are soft to the insurers, which I think public option is less tolerable to. And it gives the public sort of something tangible to grab on to. You know, in a public option I will have this new thing that I can purchase. Particularly people who have sort of familiar with logical reasons, sort of philosophically opposed to the idea of private insurers.

I don't know exactly how that plays out, but I think that is a consideration. You know, in terms of there are concessions that are being made, I think this is all about where the rate settles. And I think it's, you know, hard to know how that plays out. I think certainly where some of this has played out and in the sort of state/quasi-public option debates, you know, the rates have often ended up not being that aggressive, and I do think there's a question of, you know, in a federal public option debate whether the sort of same forces would drive toward that outcome.

MR. MURRAY: If I could just make a comment. In that first session with the panelists I kept thinking when some of the questions were asked about our price is too high and various other issues were floated. I kept thinking what would Uwe say? And with regard to this issue of politics, I'm certainly not a political expert but I think what Uwe would say is that we just haven't experienced enough pain yet. And the political balance will shift when we get to the point where we've experienced so much pain that the negative externalities associated with not doing regulation outweigh any perceived negative

externalities associated with doing regulation. And we will get to that level at some point.

An analogy might be global warming. You start to see massive wildfires in the west and huge number of hurricanes in the Gulf, and then finally that gets people to wake up and experience a sufficient level of pain that might galvanize political support.

So unfortunately I don't have an optimistic picture with regard to the politics. I think we just, as Uwe say, need to experience more pain.

MR. FIEDLER: You know, one of the things that sort of comes up when we talk about these issues is that on one hand we frame it as we worry about high prices in many settings. But then this other argument kind of creeps in, which is that we think that some of these mechanisms like rate regulation or public options and so on might actually be good for the finances of certain hospitals. And politically speaking, sort of to your question, Christen, that seems to me to be part of potentially if this were to happen to any type of sort of winning coalition is these are rural hospital story, right? This idea that for not as much money we can basically use some of these savings to essentially prop up hospitals in areas that are financially struggling via precisely the mechanisms that could ironically actually contain costs in other settings.

MS. UCCELLO: So I just want to add one more thing with respect to, this is not a whether price is too high or right or whatever. But I think we're entering a period where we're paying a lot more attention to equity issues. And so I'm wondering if moving forward we're going to be discussing, politically or otherwise, just how -- we're spending a lot of money on health. And so are we allocating those expenditures appropriately within the healthcare system. And then also are we allocating resources wisely between the healthcare system and other types of programs?

And I just, you know, I don't know how much this is going to kind of catch on politically or not, but I think it's something that people are paying a lot more attention to now than they were six months ago say.

MS. LINKE YOUNG: Great. So shifting gears a little bit. A number of you have alluded to various ongoing or new initiatives that are happening in the states. And I'd love to hear all of you talk

about what you think some of the most exciting or encouraging new initiatives are on the state policy front and where you fear states may face risks or the major pitfalls per state wide.

So, Cori, why don't you start us off on this one?

MS. UCCELLO: So I think that states are really thinking through a lot of the issues that I raised in my presentation. And one particular issue, my understanding is that they're looking into is with respect to administration.

And if states are thinking about public options and buy-ins and those kinds of things which are similar with different names, and so they're thinking about is it worth it for them to take on these administrative and insurance functions. And as they think through that I think they're looking at well, you know, how much would enrollment go up if we, as the state, undertook these functions. Because they're going to have to expend a lot of resources to build up a system.

And if they're looking at this and see that well they're not really going to get a lot more people insured through this mechanism, then they may find it makes more sense for insurers to take on the administration rather than themselves.

And I think we've kind of talked around this too is another issue is how low they would be able to get prices. And that's going to kind of play into whether they'll get a bump up in enrollment. And the provider pushbacks I think limit the extent to which they can lower prices which, you know, may be swaying them to not take on a lot of these functions.

MR. MURRAY: I just wanted to make a comment. The initiative that I see having a lot of promise is the one that I mentioned in Rhode Island where the health insurance commissioner said that insurers can't accept hospital contract price increases in excess of CPI plus 1, and then I think it went to CPI flat, moving forward. That seems to have had a significant impact on constraining price growth. Kind of a backstop of the authority of the insurance commissioner.

And I read an article and I've talked to people at UC Hastings recently that there may be insurance commissioners in various states have considerable authority to implement restrictions of this nature. And in fact there was an article by Marty Gaynor and Paul Ginsberg recently that mentioned this

as an option. So I think I see this as an optimistic area.

As I mentioned before, that proposal does not address existing price disparities and price discrimination, but there are ways of addressing that by looking at individual provider's benchmark to Medicare, their commercial prices. And then having restrictions that would force some degree of convergence between the highest priced providers and the lower priced providers.

So that's an area that I would suggest states look at in more detail in terms of the regulatory authority of the administrative agency like the insurance commissioners.

MR. IPPOLITO: You know I'll just make a quick point that, yeah, so, you know, one of the challenges with state base approach is of course that you have ARISA and so you're somewhat boxed in in the kinds of things you can do. I will say that it strikes me that if part of the goal is trying to understand, and I think it should be, trying to understand what do people really value, what do they not value. Then it does seem like we may need to think more federally in the sense that you can then start to think about things like well, what if we think about policies that require employers to start offering plans that are lower cost. See what people choose. If they don't choose that plan or if they do choose that plan, then fine, right? See who survives in that kind of environment. Put the pressure on the market by letting people actually see what they're actually willing to pay for. But do it in a way that essentially mandates a little bit more choice than there may be right now.

When I look at states I see a lot of cautionary lessons. And, you know, obviously there are a number of things like what Bob's talking about, which we haven't seen pan out yet. But like Maryland, for example, is often held up as sort of the most successful version of our state-based approaches. And there, you know, it's been a pretty mixed evidence on cost containment over time. Some of these what sound like theoretically sort of issues and concerns like political capture, are quite real in that state. And so I do think there are a lot of lessons. I'm not sure there's any particular sort of shining success story that really sort of stands above everything else.

MR. FIEDLER: The one thing I would say, you know, in our current environment there are some constructural challenges at the state level. I think this is particularly true in the individual

market, but it's also true in the group market. Which is that if you succeed in reducing prices and thereby reducing premiums, you reduce the value of the premium tax credit and those savings accrue to the federal government. And if you reduce prices and thereby premiums from the group market, some of those premium savings get converted into either profits for your firms or wages for your workers, and those also translate into higher revenues for the federal government rather than incurring to you.

So I think, you know, the tradeoff at the state level, you know, the political pain associated with taking on your providers when a decent chunk of the savings is going to accrue to the federal government not to you to use to expand coverage or do what other else, I think does make the policy restrictive at the state level.

MS. UCCELLO: And I should have mentioned this before but, you know, one state has implemented a public option. And I think one of us may have mentioned that but, you know, it's Washington state. And they did it through insurers, you know, they didn't build up their own system. So I think that's, you know, something to keep in mind in terms of other states who are trying to make these decisions.

And their aggregate provider contracting can't exceed 160 percent of Medicare, and I think there's a floor for primary care. And I looked at some of the premiums that were filed, these were initial filings, not the final. But, you know, sometimes those premiums were the lowest, sometimes they were the highest, you know, it was definitely not always the case that the public plan offered by the insurer was going to be the lowest priced in the area.

So, you know, I think we need to look at what's going on there to better understand how it might happen elsewhere. And I think it also really depends on local conditions. What other plans are operating in the area, are there already Medicaid managed care plans that are operating in the ACA market. Because you're going to have a different result of how much better a public option can do in that environment versus another area which doesn't have that kind of plan.

MS. LINKE YOUNG: Right. So another concern that we hear from a lot of stakeholders is fears about how policy intervention might affect or just rob ongoing investments in alternative payment

models of various kinds, efforts to sort of shift our payment system in ways that move away from volume and towards value.

Bob, can you talk a little bit about some of those concerns and how you all addressed them in Maryland and some of the lessons have a broader picture here on encouraging APMs in a context where we also are trying to be more aggressive on rate regulations?

MR. MURRAY: Sure. I think there's always been a criticism of rate regulation, state based or otherwise, is that it will squelch innovation and payment. I would tend to take the view that most innovation of payment has come from government, ironically.

In Maryland, I was there at a time when managed care was very dominate, and managed care companies were proposing fixed payment contracts, either bundled or on PMPM basis. And our agency was able to accommodate those if they met certain requirements in terms of not providing hospitals with unauthorized or significant discounts. In other words, if they produced value, they reduced utilization or they otherwise helped the facility lower cost, they could be approved. So I think Maryland's approach shows that alternative payment mechanisms can be accommodated in the context of a regulatory structure.

I'd also add the point that rate setting itself is not anti-competitive. In fact there's a lot of evidence from Maryland and other countries where when you set a price it does allow, particularly when there's market power that creates a monopoly price, it does allow for both providers and insurers to compete on other dimensions. In Maryland when the rate setting system started, Blue Cross had 80 percent market share. And after rate setting came in, you didn't have to be a big behemoth to compete in insurance market, and we had significant entry of insurers into the Maryland market. That was true in two of the other three rate setting states, all payer rate setting states.

So this idea that price regulation needs to be rigid and would squelch all forms of competition, is not correct. In fact I would argue that price regulation can stimulate competition in other areas, other dimensions, like market entry, like quality, like consumer and patient empowerment and choice. And that's also a sentiment that was shared by someone like Allen Antobin, who contemplated it

in administrative pricing system in the context of his consumer managed care driven proposal back in the '80s and '90s.

MR. FIEDLER: One thing I say, you know, I think one advantage of the out of network cap approach is that you avoid this whole set of questions. Since you're not regulating in network prices, you know, providers and insurers can work out whatever alternative payment arrangements they want. I'm a little bit concerned frankly in the context of the network cap that you end up with another problem, which is that providers simply say listen, if you don't sign a contract with me I'm not going to accept your patients. And so an out of network cap doesn't give an insurer as much leverage as we might hope.

I think there are ways you could think about coping with that problem, you know, coupling an out of network cap with some requirement to accept patients in the absence of a network agreement. So I mean all of these things have tradeoffs. But I do think, you know, one advantage of approaches that don't directly regulate in network rates that you can point (inaudible).

MS. LINKE YOUNG: I want to think of something Bob mentioned there and talk a little bit about consolidation or lack thereof in payer markets rather than provider markets.

So, Ben, can you start us off with your thoughts on risks or potential benefits related to payer consolidation as policy makers might consider moving forward here?

MR. IPPOLITO: I don't know that I have very developed self-views on that question. No, I mean it's kind of an interesting question. I mean certainly in the context of what Matt was talking about, I mean one of the just mechanical things that does get a little bit interesting is that if you think about defining, either defining an outside option via an out of network price cap or more like if you do a public option or obviously explicit rate regulations, that you would expect probably quite a bit of compression in the private market in terms of sort of what is offered.

And so one of the questions, I guess it's just an empirical question, and maybe it's not, maybe I just have strong views, is how much competition, like what Bob is describing, would remain. All right. How much differentiation would exist, I guess, amongst say, how you organize the plan, you know, the kinds of other amenities already featured in the plan, versus just, you know, there's a single plan that

kind of defaults to whatever the implicit sort of equilibrium price is that's determined by the public option or other intervention. But I don't know what the answer would be, I think it would just be an empirical question.

MR. MURRAY: The one point I would add there is that while there has been evidence in concentrated insurance markets the prices are lower, insurers, particularly large insurers, are more worried about their relative price advantage compared to their large competitors than they are in controlling overall health expenditure growth. And as you know, 60 to 70 percent of their accounts are now cost plus accounts, and so they're just pure pass-throughs to the employees and employers that are self-funded.

So those two dynamics, particularly when confronted with massive consolidation and the power of providers that have been consolidated, are two things that really limit the effectiveness of insurers, even if they are consolidated, to be good stewards of cost containment. So that would give me some degree of concern as to whether, you know, consolidation in the insurance industry is really any salvation here.

Again, I think, you know, an emphasis needs to be placed on additional forms of regulation, regulation that preserves the private insurance function. And, as Matt said, maybe focused on out of network caps or variations of that such as what occurs in the Medicare Advantage market.

I don't know what the political feasibility or legislative feasibility of this is, but why not allow MA plans to accept privately sponsored insurance enrollees and then have a similar structure where there's a cap set on their payments similar to the laws for Medicare Advantage, and then try to have them be engines of cost containment moving forward. Not only for Medicare but also for the private sector.

MS. LINKE YOUNG: Great. So I want to turn to a couple of questions that have come in from the audience, in particular on what we mean when we talk about compelling provider participation into a public option.

We've had a couple of questions about what the policy mechanics are there and how those policy tools might look different in the context of hospitals versus physicians or other provider type.

So, Matt, I know you've done some thinking on this. Do you want start us off talking about what it might mean for a public option to require provider participation?

MR. FIEDLER: Yeah. So I mean I think there is sort of two pieces within that question. There's like what does participation mean, and then what is the stick to enforce participation, that's sort of a separate but related question.

So, you know, in terms of what does participation mean, I think you'd need to define some set of asset standards. So say, you know, if someone enrolled in this public option calls up and asks for an appointment, the sort of wait time for that patient can't be, you know, more than X amount longer than a sort of similar situated patient in this other set of hypotheticals. And I think that is you could, or alternatively, you know, you could think about setting that sort of requirement in sort of absolute terms, but I think that's tricker in practice.

You know, enforcement of that is not trivial. You would need to be thinking about, you know, what your audit structures are, what your complaint structures are and how you would take enforcement action on the basis of those things. But I don't think it's an impossible regulatory lift to think that you might not be able to set up something like that. And it doesn't necessarily have to be perfect, it needs to, you know, do enough to make either the public option or your price cap if you're backing it with, you know, this sort of access requirement, you know, make signing to at least some degree.

In terms of how you enforce it, you know, I think you could do a bunch of different things. I think you could say that, you know, no provider that is not in compliance with the access standards can be covered under other plans in the individual market, for example. And at state level there's direct licensure tools you could think about using.

There's a whole bunch of ways you can make it in the provider's interest to comply. And that question is, you know, which one is sort of most convenient and most powerful in view of contact.

MS. LINKE YOUNG: So a related question with that is about the importance of a level playing field for the public option in the marketplace. Matt and Cori, you both talked about this a little bit and talked about what it would look like.

Cori, can you back up a step and just talk about why that level playing field requirement is so important as a design consideration and why we care so much about building that level playing field?

MS. UCCELLO: Well I think what we're taking here is the assumption that we want the public option to be participating in a market that still includes private plans. And so you would need the level playing field to make sure that the private plans are not being disadvantaged unfairly due to advantages in the public plan. And so I think that's the broadest way of thinking about things.

And then when we think about those particular rules, you know, we talk about, you know, risk adjustment for example. You know, if we want a plan, the public option, to be participating in this risk adjustment system, that's really difficult to do if it's operating under different rules with regarding what the benefits look like, what the rating rules are, those kinds of things.

So there's the idea of if we want, you know, a competitive marketplace with private players to still be participating, the level playing field helps facilitate that.

MR. FIEDLER: One of the ways I think about this is, and I think it's most concrete in thinking about a scenario where, you know, maybe we could get the public option ends up being much worse at managing utilization. That in that case I think we would probably want much of the enrollment in that particular market to run towards the private plans rather than public option. And I think we don't want to end up with a policy structure that, you know, put policymakers thumb on the scale and drives all the enrollment up, even if we think the private plan is actually, you know, better at managing costs.

I think the flip side of that is we wouldn't want to structure, I mean I think we often talk about level playing field, making sure the public option doesn't have unfair advantages. I think we also want to make sure that the, you know, benefit design and risk adjustment structure is such that the private plans don't have, you know, undue advantages with respect to risk selection, which could be, you know, create incentives through the private plans that do things for their benefit designs that are potentially pretty bad for plan enrollees.

So, you know, I think in some ways I think the motivation for a level playing field may differ a little bit on what particular part of the playing field you're talking about.

MS. LINKE YOUNG: So another issue that many of you have talked about is how limits on available data have panned our ability to understand what's going on in markets today and that keeps us from being able to design the right policy tools or calibrate those tools effectively.

I'm interested in hearing more from all of you about where you think those data limitations are most important and what might be done in the short to medium term to potentially progress some of those data issues.

So, Bob, why don't we start with you and the Maryland experience, etcetera, and sort of other lessons there?

MR. MURRAY: Yeah. I'm doing some work with Johns Hopkins University and Jerry Anderson in various states, providing technical assistance. And the biggest challenge that states face of course, relate to getting data from the self-funded plans because of ARISA.

In Maryland the approach was for the state agency to require providers to send in data to the rate setting commission, which ARISA would not effect and would not restrict that type of data collection effort. So the idea of repealing ARIS is pretty unlikely.

One alternative approach would be to have states enact legislation to get the data directly from providers, starting with hospitals and then branching out to other providers.

The administrative burden associated with that is not that significant. It can be done, and Maryland's a good example of how it can be done very effectively and efficiently to try to get over that particular hurdle. So that would be one area that I would suggest we look at.

The other issue with regard to data as it relates to states, those that are trying to benchmark to Medicare oftentimes finds it's extremely difficult and complicated to do so between commercial prices and Medicare prices, particularly on the outpatient side. So if there could be tools, analytic tools that CMS provides, I know they already provide very complicated formulas for that type of conversion. But if they could simplify that and provide analytic tools to states to make that type of link so states could benchmark to Medicare more effectively, that could also be very helpful.

MR. IPPOLITO: You know, the arguments for various types of rate regulation or similar

proposals is obviously the strongest when it's the theoretical and the empirical evidence have all worked together to paint a picture that look, we have high prices that don't reflect value, right?

So we have a good example recently surprise medical billing, right, so that's an example where we have extremely clear data actually, and we have extremely clear just theoretical conceptual points too. Where we think that look, this is a case where this is defined by the lack of choice. This is defined by the inability for people to really sort, and so we have very strong evidence that what we have here are really temporary monopolies that are able to extract great rates that provide very little value. Right? That really provides a very solid foundation for what's still a very difficult political involved challenged and so on, but it obviously makes things much, much easier.

I think if I were to look to what piece of evidence would I love to see that we don't have, I honestly think it's the linkage of the pricing information to all of the other stuff that we don't see very often, right? Our pricing data bases don't have much information about amenities and quality and so on, the kinds of things that we want to know. Why are people willing to pay for this place? Why do they demand that this hospital, this doctor, whatever, is in the network, right? That kind of evidence strikes me as being the strongest. Maybe we'll find out that it's really low value stuff, in which case suddenly the case for broader based regulation approach is stronger. But I think that's probably our biggest data weakness.

MS. LINKE YOUNG: Another audience question we've gotten is about how to -- oh, go ahead, Matt. Go for it.

MR. FIEDLER: One thing I'll jump in on. This is something that Christen and I have been working together of late. You know, there are a bunch of opportunities to strengthen state (inaudible) and I think this can be useful for both the answering some of the questions Ben is asking is, you know, what is the tradeoff between price and quality here but it can be useful at the design stage of, you know, what are prices being paid providers in my particular state and what does that suggest about how to design the policy.

Now obviously you see it's because of the latest addition faced some real issues day to day to collect, so I think there are, you know, in terms of laying a better evidentiary foundation for this to

date I think dealing with the base problem and then looking at options to make our sort of state systems a little bit more than some of its parts in terms of seeking the national policy questions would be worthwhile.

MS. LINKE YOUNG: Another question we've gotten from the audience is how to think about policies to allow older adults to buy in to Medicare on various terms in the context of the typology we've laid out around a public option. Do you see a proposal that would extend some form of eligibility into the Medicare program for older adults to have effects that are potentially similar to a public option, and how would those effects be similar or different?

So, to Matt, why don't we start here with you?

MR. FIEDLER: So I think those proposals are a lot more complicated to think about. And what you then have is an individual market where some people are choosing between the private plans and quasi-public option, and some people aren't because they're not old enough.

And I honestly have not fully thought through what I think the equilibriums of that market is, but I do think it may end up having to be something bifurcated, where basically everyone under 55 is in private plans that look a lot like the private plans we have today, and the people eligible for the public option are in the public option. Because the sort of competitive thing, and I talked about before I think can't really get off the ground.

I think there's a deeper question from my perspective of, you know, if we think revision prices is the right policy and public option is the right tool to do that, the policy rationale for limiting to that only to people in the 55 to 65 age range strikes me as not obvious.

MR. IPPOLITO: Similarly, if part of the goal is to target, you know, increased insurance coverage to sort of where the demand or the need is greatest, it's sort of an odd allocation that's it too, but I mean to the public option equilibrium question. I mean it fundamentally, I mean the size of that group is going to play an important role, right? Is it a small incremental extension of Medicare? Well if it's that case then probably what Matt outlined sounds exactly right? The larger that group becomes, the more it seems like it approximates the public option itself.

MS. LINKE YOUNG: Okay. With our last couple of minutes here I want to go around

and ask folks to reflect on the discussion we've had, to just weigh in on what you think the biggest risk to bad or counterproductive policymaking in this space is. What are you most worried about as you imagine potential policymaking to potentially bring the government sort of more into the healthcare prices?

So, Cori, why don't we start with you?

MS. UCCELLO: I guess I just go back to my trying to make sure the solution is fitting the problem in understanding all of the interactions that need to be considered when looking at things. So something may just sound good, right, but then when you look at kind of how you would actually do it, it's a lot more complicated and getting the details right probably matters.

MS. LINKE YOUNG: Ben, you want to go next?

MR. IPPOLITO: Yeah, I'll keep being negative. What I would say, I mean genuinely so I have absolutely no problem with the answer ultimately being that actually most of what we observe is genuinely high prices that reflect variable values. If that's the answer then like great, let's just whack the prices way down and now we got a bunch of money to spend on other stuff that we care about, right? Like I like schools too, I like all sorts of other things.

What I care about is that some of this stuff is real value that we actually like a lot, right? And we don't understand that and we're going to miss it when it's gone, right? Particularly if we're thinking about things that are done at the federal level where we kind of have one big hammer that's super, super powerful but we don't really get to sort of test what we did in the same way. So I like ideas that put pressure on the market in part because we get to see people sort of react to those things. We get to see them react when the cost of their employer insurance is more real, it's more accurate. I'm even fine with policies that regulate that marketing ways to try and push that, right? Try and encourage employers to offer lower cost plan, see if people will take them. See what they'll give up. And part of what we do is we get to observe a bunch of different things, we get to see a bunch of different little experiments and learn something about that.

And so I think that's the big thing for me is that we're kind of flying a little blind, I'd like to be able to learn about this stuff, and I think sort of decentralizing it a little bit is one way to do that.

MS. LINKE YOUNG: Bob, how about you?

MR. MURRAY: Well I think the biggest risk is that we continue to lose the picture of the forest from the trees. You're talking about things like well, what's the value of additional quality or other amenities or enhancements. Just compare us to the rest of the world in terms of the amount that we spend on healthcare, 18 percent of GPD versus about half that amount in other OECD countries. MedPac quantifies that Medicare payments are about 50 percent above payments at hospitals at OECD countries, after adjusting for wage differences and cost of living. And private sector prices, this is in 2016, were 100 percent above payments to hospitals in other countries.

Again, I would harken back to what Uwe Reinhardt has said, which is our principle problem in this country is that we have such fragmentation on the purchasing side and a failure politically to consolidate, have market power for healthcare purchasers compared to every other country in the world. And if we continue to do this we will continue to be facing a very, very powerful provider industry and prices will continue to go up. It will result in erosion in quality and access and we'll just suffer more pain.

So I think the answer is what Uwe Reinhardt had recommended back in 2012, which is enact a public option, enact some sort of price regulation, something that can put more power on the purchasing side, because until we do that we'll still have these significant health cost problems and access and quality problems.

MS. LINKE YOUNG: Matt, final thought from you on this theme?

MR. FIEDLER: Yeah. The one thing I would say, which I think picks up a little bit on what Ben said and what Bob said is, you know, I think it's important, I think one feature of the political system in many areas but in this one too, is that it exhibits a, you know, the great status quo bias and lots of aversions in a sense that, you know, when we're looking at a policy change and there's a tradeoff involved in that policy change, which almost all policy changes involve, the downside of the tradeoff kind of often looms particularly large, so, you know, in this case I think sometimes once you've conceded there might be some tradeoff between prices and quality, which to be clear I think there very well could be and

there probably is to some extent, there's a tendency for that to be the end of the conversation rather than the start of the conversation about how to weigh cost to benefits.

So I think if we sort of go forward, and this could be I think one useful discipline is to think about whether argue on implementing a regulation that reduce prices 10 percent would be compatible with our view about removing a regulation that reduces 10 percent. And I think in many cases people's instinctive reaction to those policies would actually be pretty different, even though they are in fact identical choices. And so I think, you know, being disciplined ourselves in trying to avoid at the creative sort of lost aversion and set co-alliance is actually pretty important.

MS. LINKE YOUNG: Great. Thank you. And thank you so much to all of our panelists for a really fantastic discussion and to our audience for joining us today.

We hope to see you again in two weeks, on October 7 at 2:00 p.m. Eastern for our third panel on lessons from the international experience in determining healthcare prices.

So I hope everybody has a great afternoon and rest of your day. Thanks.

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Carleton J. Anderson, III

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