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How Unaffordable is Health Care and What Can We Do About It?

Larry Levitt: Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of the Health Wonk Shop where we regularly dive into timely and complex health policy topics with experts from a variety of perspectives and experiences. Affordability is the buzzword of this campaign season, and our polling shows that healthcare tops the list of economic worries for voters. This should hardly come as a surprise. The premium for a family health insurance policy is now about $27,000 a year. Deductibles average about $1,900 per person and out-of-pocket premiums under the Affordable Care Act are skyrocketing due to the expiration of enhanced premium subsidies at the end of last year. US presidents have said for decades that the cost of healthcare is unsustainable.

Back in 1971, Richard Nixon warned of a cost crisis as national health spending climbed to the then unthinkable level of about 7% of the economy. Now healthcare spending tops 17% of GDP. There must be a word for something that keeps going even though it seems unsustainable. This is a big and complicated topic, and we have just the people to tease it all out. Ashley Kirzinger is director of survey methodology at KFF. Sherry Glied is a professor at NYU and wrote recently about healthcare affordability in JAMA. And Ben Ippolito is a senior fellow at the American Enterprise Institute and has written and testified about these issues as well.

A little bit of housekeeping before we get to the discussion. If you have questions, submit them at any time through the Q&A button in Zoom, which you might find under the more menu at the bottom of your Zoom app. We'll get to as many questions as we can. Note that this session is being recorded, and an archived version should be available later today, and we have ASL interpretation available to access it. Click on the globe icon in the Zoom control panel.

Now let's jump in. Ashley, let's start with you. Where is the public on affordability? What is their level of worry about healthcare costs? And what have they experienced in terms of problems paying for healthcare, and what are the implications of those problems in their lives?

Ashley Kirzinger: Yeah, thanks Larry, and I'm happy to be here. The cost of healthcare is now the top financial worry for US households, outranking groceries, gasoline costs, utilities, and rent or mortgage. And while we know that not everyone gets hit with high healthcare costs at the same time, more than half the public now say it is difficult for them to afford the cost of healthcare for them and their family

members. And it is even more difficult for lower income families and of course people without health coverage. KFF has been tracking public perceptions of healthcare costs for decades. And what we used to hear from people, especially since the passage of the ACA, is that insured adults could really budget for their predictable healthcare costs like their premiums or their copays and would only really worry about instances of an unexpected medical bill due to a medical emergency or a really difficult diagnosis.

But more recently, and maybe as a result of what you were talking about previously of more individuals being enrolled in higher deductible health plans, we are hearing individuals are still worried about that big medical bill, but now are also struggling to afford the cost of their routine medical care. What does this mean? Well, it means that individuals are more likely to report putting off routine medical care. They are less likely to take their prescriptions as instructed by their provider. And when they're forced to, they actually forego other household expenses in order to afford the care that they or a family member may need. The issue of affordability is a pretty big buzzword right now, as you said. But behind that rhetoric, what we're really seeing in everyday life captured in our polls, it is clear from what people are telling us that healthcare is playing a major role in people's affordability concerns.

Larry Levitt: So Sherry, let me turn to you. When you as an economist think about healthcare affordability, and as I said, you've written about this recently, how do you diagnose the problem?

Sherry Glied: Affordability is a really complicated problem because it means so many different things, and it encompasses so many different things. One of the aspects of it that I think actually makes it even more complicated, I was just thinking about it some more, is that we usually think of affordability as in the context of all the other things you need to buy. So people's experience of healthcare affordability could simply be a function of changes in the price of gasoline or food, even if the price of healthcare itself doesn't change because they have less money available for those things. So this is a problem that is both a function of what's happening with healthcare spending and what's happening with the rest of the economy overall. So we have a general sense of people feeling a lack of affordability and a high bill that comes along that's a healthcare bill that they may really focus on that as the source of a lack of affordability.

But more generally, there are different components of healthcare, and we can think about affordability along all those dimensions. One of them is how much people are paying for premiums. One of them is how much people are paying out of pocket when they need things. One of them is what happens when there's an emergency. And we can see those affordability concerns showing up in each one of those dimensions.

Larry Levitt: So, Ben, do we have a healthcare affordability problem? How would you diagnose it?

Benedic Ippolito: Yeah, I mean I'm in the Sherry camp where it's affordability to whom and in what context. The way I think about this is from a global perspective. The things that really resonate with people all ultimately stem from the underlying costs of care. If care gets a lot more expensive, providing more generous coverage or subsidies is more expensive and vice versa. There is this irony that I often come to, maybe irony is the wrong word, but whenever this affordability issue comes up, the things that really tend to resonate with people often aren't really what I spend a lot of time thinking about in terms of that global cost picture that I think actually drives the underlying issue. Things like out - of-pocket costs get a lot of attention for obvious reasons. That's only 10% of our total healthcare spending, and that's actually historically just about a historic low.

Drugs get a lot of attention. That's only about 15% of what we spend. Insurance premiums get a lot of attention. Most of what that really reflects is the underlying cost of care. And so in some ways I think about the affordability issue as focusing on what's salient to people, that's what resonates, but what drives the issue is the underlying cost of the care. It's the hospital prices, it's the cost of doctors, it's the cost of drugs that feeds into this broader issue that's just become salient in very different ways.

Larry Levitt: So let's talk a little bit more about that underlying cost. And I wrote last week in JAMA about, we talk an enormous amount about drug prices. Hospital costs are a much bigger component of that global health spending picture. So sometimes I'll post on social media about the Affordable Care Act, and we'll get the predictable responses. Well, why do they call it the Affordable Care Act? It's the Unaffordable Care Act. There's this, I think, a sense among some that healthcare costs contain our way out of this problem. I mean, no question the underlying costs are high. We spend roughly double what other countries spend per capita. But could we address people's affordability problems by addressing the underlying cost of care? Could that truly solve the problem? And, Ben, maybe I'll start with you.

Benedic Ippolito: Yeah, I mean, in some ways it's necessary. The alternative solution is just to try to go with more of a subsidy approach or just an approach where you lower people's out - of-pocket costs, you lower their premiums via say federal or state funds. I almost think of that as if you live on a big river, each town wants to dam up the river, and that means that they're not going to get floods locally, and you locally solve the problem, but you end up with this river that's raging downstream because it has nowhere to go.

And so I think of it the same way. If you insulate everybody from costs via just a subsidy approach and just protect them from the actual cost that they observe, that's wonderful in the short term, but you've even further desensitized people from caring about the global cost picture.

And so you can't really in the long run solve the affordability issue without at least combining that kind of approach with something that thinks more holistically about the major cost drivers. And as you say, the major cost drivers are the things that people don't focus on and tend to be a little more sympathetic about. It's hospitals, it's doctors, and certainly drugs and other things, but those things outweigh the others.

Larry Levitt: So, Sherry, I mean the piece you wrote in JAMA, you talked about different groups of people. I mean, healthcare spending is not distributed equally across the population. Are there some people, as Ben says, probably have to attack this problem in both ways, subsidies for some people, but addressing the underlying costs as well. Who are the groups that are particularly vulnerable who have been particularly hit by high healthcare expenses?

Sherry Glied: So I think we actually have to step back a step because right now healthcare expenses, and we've had a year or two of high healthcare cost growth, but actually we've come off a really slow growth period. It's shocking when you look at the numbers that we are facing in affordability crisis right now because relative to even a decade ago, things are actually not looking that bad at the aggregate level. So that makes you really think about for whom is there an affordability crisis right now? And I think there are a couple of groups that strike me as being particularly vulnerable. One are people who have really bad health events, and we have tried to protect those people through health insurance, but the nature of health insurance has provided more protection to people who have lower costs over time and less protection to people who have really high costs.

So there are still people who are hitting up their out-of-pocket maximums and spending a great deal of money out of pocket, and that's probably not a good place for us to be putting a lot of risk. So there are ways to protect people who experience really bad health events by protecting those people at the very high end of the distribution. I think right now we also have a phenomenon of a couple of big routine expenses for people that are not well covered by insurance, and I think we have to struggle with it a little. One is GLPs, right? Only less than half of employer plans cover GLPs for obesity. I think this is your data. And lots of people are using them. And so all of a sudden we have a very large group of people who are experiencing an out-of-pocket healthcare cost, a great one.

It's a wonderful new drug, but they are experiencing a much bigger cost than they would've in the past. And I think that's one population we hadn't expected to see in these data. Another population I think that we see are people who are using out-of-network mental health services. Again, a large population of people, not extremely high spenders in total, but who are experiencing a regular large out-of-pocket cost. And I think those are populations we need to struggle with a little bit that are not going to be solved. That's a problem that's not going to be solved by addressing total health spending.

Larry Levitt: Ashley, let me bring you in. In our polling, so you find these widespread worries about healthcare costs. We even find what, 40% of adults have some form of healthcare debt? I mean, very widespread. But does the polling pick up more acute issues for people with chronic conditions that GLP-1s might address or more serious health conditions?

Ashley Kirzinger: Yeah, it's really interesting. There's a lot of conflating factors that could be playing a role. We have seen that people with mental healthcare needs have higher healthcare costs. That may be due to the fact that they're younger, they tend to have lower levels of income, but also maybe due to the fact that they are seeking care outside of a network or we're requiring on more prescription medications. Chronic conditions, obviously people with chronic conditions and serious illness have more routine medical care, but this is a population that also seems to be able to navigate the healthcare system a little bit better. They struggle with prior authorizations and delaying care and some insurance providers denying care, but they seem to be able to navigate the system and be able to handle the routine costs, and they're more likely to hit their deductible and so therefore are protected by some of those routine costs as well.

I think what is really interesting to me is this concern about affordability is not hitting just the highest users of healthcare, but our middle user group. So people that are dealing with maybe one diagnosis and haven't been able to navigate the system before and are now dealing with higher costs than they've seen in the past and having to utilize a health plan that they maybe haven't utilized in the past and weren't aware of their high deductible plan and then didn't budget for this kind of out-of-pocket cost that they're experiencing. And that's why we're seeing that four in 10 number of having some medical debt.

Larry Levitt: I mean, this issue of budgeting is important too, right? When we're polling, we're asking about different types of household expenses. Gas used to be a predictable expense. It may not be so predictable at the moment. But other things like your rent, your utilities, they don't change that much from month to month. Healthcare, when we ask people, what are you worried about? That's a very uncertain expense. So people worry about that.

Ashley Kirzinger: Yeah, we used to separate, right? So we used to ask about an unexpected medical bill, and that was always at the top of people's worries because that was something that they couldn't predict, right? And so, yes, of course I'm worried about someone getting hurt or having a diagnosis and having this very high unexpected medical bill. But now what we see is just general healthcare costs are up there too. And I'm wondering if it's because our budgeted healthcare costs are taking bigger and bigger chunks out of people's paychecks. Kind of what Sherry was alluding to at the beginning is that when things are becoming more expensive across the board, then we're looking at our budgets and seeing what's eating up the biggest chunk of that, and healthcare is.

Larry Levitt: So we've been talking a lot about these people with chronic conditions, serious health conditions, mental health conditions. I mean, income is a factor here as well. And, Sherry, you wrote about this also, that the Affordable Care Act by its structure had to define what is affordable health insurance, at least the premiums, ranging from a couple percent of income for the lowest income people up to 10% and then enhanced subsidies, which expired at the end of last year, lowered that across the board and capped premiums at 8.5% of income for middle income people. We've been talking about this for years, right? And I think those of us who work on these issues pull these numbers out of a hat in a sense. What is affordable? Is it 2%? Is it 5%? Is it 10% of income? I mean, Sherry, in the work on the ACA and your work since then, how should we be thinking about this?

Sherry Glied: So the answer is nobody knows the answer to this question. And it's interesting. I was just looking back a hundred years. There was a commission on the cost of medical care in 1927, and they were asking the question, how much can people afford to pay for healthcare? And they couldn't come up with an answer then. Of course, they actually had no healthcare then either. So they were trying to get people to be able to afford something that was pretty useless for them. Now we have something that's very useful to people. And there are two sides to this question. One is what happens to people's incomes? How redistributive are we willing to be? How much are we willing to protect low-income people and to provide low-income people with access to the same care that is available to higher income people? That's a normative question, and people will feel differently about it.

The second piece of it that I think makes it really complicated is the difference between 1927 and now or the GLP question, right? Should people be expected to pay more for healthcare if healthcare is more useful to them? I'm trying to remember who it was, Mark Pauly or some other relatively conservative health economist used to ask the question, "Would you be willing to buy 1975 health insurance at 1975 prices?" And the answer generally is nobody would be willing to do that. And I don't think most of us would be even willing to buy 2015 health

insurance at 2015 prices. So some of this is also how much as a nation do we think we... Again, it's a normative question, how much of people's budgets ought they to be spending on healthcare? And then a final dimension of this is as other things become more expensive or cheaper, how does that change our calculus about how much people ought to be spending for healthcare? If housing becomes more expensive and people don't have as much income left, does that mean that they should spend less on healthcare?

Again, there's not an answer. We did surveys before the ACA passed trying to ask people, experts, regular people. The range of answers was astonishing.

Larry Levitt: Yeah. I mean, a lot of people end up with 10% as the answer just because it's a round number.

Sherry Glied: Nice round number.

Larry Levitt: Yeah, So, Ben, I mean, Sherry framed... Partly this as a redistributive question. How much should people pay, and then how would we pay for that? How would we pay for those subsidies? Should we be thinking about this more broadly when we're talking about healthcare? It's not just in what we can afford. It's not just the out-of-pocket costs, it's not just the premiums, it's not just what employers are spending, but it's where is that money coming from, which ultimately is taxes, right?

Benedic Ippolito: Yeah. I actually love the example that Sherry's using for GLP-1s. It's such a good example for this affordability conversation because historically they're this unicorn in the drug world where they're wildly cost-effective at their current prices, but yet they're a perfect example of even when something's really valuable, it presents this fundamental budget problem that people are facing, and it would face employers and so on if you force people to cover it. It's not just taxpayers. I mean, there's two ways to think about this. We can essentially have the federal government or state governments, implicitly taxpayers, cover a larger share of the burden. Some people have this discussion as if those taxpayers are just fundamentally different entities than the people getting the care. Taxpayers are the general population. And so we do need to think about being responsible and affordability from their perspective too. I mean, we can't just simply put the bill on them and act like that's some separate entity that isn't us.

The other thing we can do, and we've seen different efforts that are in this bucket, is we can essentially try to regulate what insurance looks like to try and protect people like Sherry's talking about in the tails. We can have rules that say you ought not to have a greater total annual out-of-pocket exposure of X percent of your income or Y dollars a year. Well, that doesn't just disappear into

thin air, that manifests in higher premiums. And so suddenly everyone has to shoulder higher premiums in order to offset that. And so that's the reason why I often come back to this issue of there's no getting around the underlying aggregate costs that you're grappling with.

And I love that Sherry brought up my favorite factoid to bring up during these conversations is the fact that with the exception of the last two years, we have had 15 years of the slowest health cost growth this country has seen in modern history, which is relative to economic output. We've hovered around 17% of GDP is what we were spending on healthcare for 15 plus years now. That's really exceptional for our perhaps modest history or our unimpressive history on this issue. And so the fact that people are worried about it in the current climate does make me even more worried if we are approaching a faster growth rate, which we may be.

Ashley Kirzinger: I just want to jump in on this because I think the GLP-1... I agree, the GLP-1 example is really telling, and we have a lot of wonderful polling on this. And we have found that even GLP-1 users with insurance coverage have difficulty affording the cost of this because it may not be covered. And we found that 14%, so about one in seven say that they have stopped using a GLP-1 because of the cost of the medication. And so if we're assuming that a GLP-1 use is beneficial to their health, the fact that they're having to stop using their medication because of cost concerns, that's really telling as a part of this example.

Benedic Ippolito: I'll just follow up on one thing though. I think that complicates that whole issue. I understand that those survey results, and you see that come up a lot, especially with brand drugs. It is very important to recognize though that when we look at empirical evidence, we also see people be very sensitive, particularly on drugs, but in other cases, to even very small levels of cost sharing. And so thinking about what affordability is, there's evidence that shows even modest two, three, four, five dollar copayments for drugs suddenly really dramatically affects use of products. And so even thinking about that issue, is that affordability? Sincerely, I ask that as a genuine question. Is that an affordability issue or at what point does society or the government or somebody hit a point and say, "We've done enough, and at this point it's a willpower or something other than just pure costs?" And Sherry's shaking her head.

Sherry Glied: I mean, the challenge, yes, of course we should do whatever we can to bring costs down at a point in time in a reasonable way. Put that aside. Everybody would like to do that. Larry, I remember when you and I first met, there was a debate about whether we should try to go with coverage first or cost containment first. I've always said go with coverage first because we have no idea how to do cost containment. No one's been successful at it. We actually

can do something on coverage. We're really bad at cost containment. There are places that do cost containment. I don't want to suggest that there aren't, but they're not in the United States. We've not done a great job of it. So we can protect people in the tails. That's a thing that public policy is very good at. And it doesn't need to cost that much in premium if you're just protecting people in the tails.

Lifetime limits cost almost nothing. Annual limits cost almost nothing in premium.

But we do have to face up to this reality, which I think I would phrase differently than Benedic did, which is that the cost of weight loss has dropped by, I don't know, nearly infinite percent since the introduction of GLP-1s. No matter how rich you were 20 years ago, you could not achieve the weight loss that a low-income person with a GLP-1 can get now. How do we think about that as a society? Are we really willing to say that we're going to let the difference between the health options available to low-income and high-income people widen considerably over time as technology changes? I'd be very uncomfortable with that. And that does mean that we probably need to do more redistribution and raise more taxes.

Benedic Ippolito: Yeah, I mean, I'll push back a little bit on just the tail challenge. I think the tail challenge can, maybe because people define the tail differently than you are, protecting people in the tails can get... It does get really expensive. I'll use an example that I'm intimately familiar with. We spent a lot of time in the inflation. The Inflation Reduction Act did a lot to improve affordability in Medicare, particularly for prescription drugs by imposing out-of-pocket limits. And it did so in a way that has literally cost hundreds of billions of dollars more than people anticipated over a budget window. And so these things do run... They start costing a lot of money very quickly. And so I'll just say that in part because some people I think probably have a lower view of what the tail, the normative question, where should we protect people at is, it can get quite expensive.

Sherry Glied: I guess where I would think about it is people where you think that the spending is going to take place anyway, and so the question is who bears the cost? So there's not a lot. That's where I'm thinking about the tail issues.

Larry Levitt: I'd say there's also a political question that you may substantively say, "Okay, it's the people at the tail. These are people with very high healthcare expenses. We need to protect them." As a political matter, that won't benefit, at least won't immediately benefit a large number of people. So you're not showing an immediate benefit to the vast majority of voters if you're protecting just that small percentage of people at any one time who have high healthcare expenses.

Sherry Glied: Right.

Larry Levitt: We've got a bunch of questions from the audience, including a lot about Medicare for All, single payer, other countries who approach this differently. I want to get your reaction. How do these dynamics, how do these questions of affordability change in a universal system where we guarantee everyone healthcare, the government has provided that guarantee? Leave aside the question of whether it's a true single-payer system where the government is providing it, but in every other country there is a different way of approaching this.

Sherry, how does that change the dynamic?

Sherry Glied: So first of all, I think it's really important to realize that concerns about affordability are not limited to the United States. These concerns exist in other places as well, and they are often related to the edge cases that we are talking about here. So it is not common across the developed world for countries to cover GLP-1s for obesity under their national health programs. Canada doesn't even have national pharmaceutical coverage at all. So the question of whether people can afford GLP-1s is a question that is going to exist in other places as well. In most other countries with the exception largely of Canada, higher income people can buy faster access to care, and they do. So we do have differentials that come about in the way that rationing happens in those countries too. And their governments spend a lot of time arguing about how much to spend on healthcare.

It is true that spending 9% is a lot better than spending 17%, but the countries that spend 9%, they don't just go to sleep. They're debating this and dealing with it and fighting all the time. Controlling healthcare class is not a one and done thing nowhere. So it is true that it would be way better to spend less money if we could, but it is not true that that would take The issue off the table.

Larry Levitt: It's interesting. We don't debate that very much, right? Ben started out talking about at a macro level what we spend on healthcare. I talked about percent of GDP, but we don't debate that very much politically. We debate a lot these out-of-pocket costs, high deductibles, health savings accounts. We debate a lot about government spending, Medicare and Medicaid spending, spending on the Affordable Care Act. We don't have these big debates anymore at least about what percent of the economy should we be spending on healthcare.

Sherry Glied: In most countries, it's not what percent of the economy, it is about how much should the government be spending, and a lot of the healthcare is under the government, so those two things are conflated. And in some countries there's a lot of debate about that increasing use of supplemental health insurance and

whether the variation between higher and low income people is increasing too much and whether that's problematic.

Benedic Ippolito: I mean, in some ways I think of that as being... We have that in the United States too because we do subsidize quite heavily people on the very low end of the income distribution. Medicaid has essentially no or nominal cost sharing for basically all services, all covered services. And that does cover 70-ish million people in the country. And so we do have some of this conversation. I almost think of this affordability conversation in part as being a conversation about where we define some of these lines. Where do you transition out of this world of Medicaid into the world of say employer-based coverage? And I think those issues are just fundamentally intertwined with this inescapable challenge that other countries do face, which is that very high income people might have a very different idea about what basket of goods to consume, how much healthcare, what's worth spending, what's not, than other people or lower income people who might, for example, prefer higher cash wages and lower insurance levels and so on.

And so that issue I think does speak to a lot of what you observe in international context where there's this supplemental private market that often emerges and creates a lot of political challenges. We have some of that. It's just domestic.

Ashley Kirzinger: I do think that what is different in this country is that we see people putting off medical care because of costs in a way that would not happen in other countries. And that is what the public is telling us that is distressing. That's what we're seeing heading into the midterm election that the voters want to hear candidates address is, "How are you going to keep me from going broke, going bankrupt because of a medical bill? How are you going to let my family member get healthcare even though we may not be able to afford it?" That is an issue that this country is really coming to a reckoning on.

Sherry Glied: Absolutely. So I don't want to suggest that there is nothing different in the other countries. I just want to say that from a political perspective, it doesn't go away. This is not a political problem that goes away. Certainly the universal access to care that people have in other countries means that at least some kinds of care are not a question of money for people. I'm a little cautious in saying that all the other countries are so different from each other that trying to make general statements about what happens in other countries is actually complicated because France and Germany and the Netherlands and England and Canada all look so totally different.

Ashley Kirzinger: Well, and this is all-

Sherry Glied: Except that everybody has access to something, right? Except that everybody has access to something, which we don't have here.

Ashley Kirzinger: Yeah, this is all incredibly complicated. I mean, I live in Maine right now where we're hearing a lot during the new Democratic primary for the Senate race about Medicare for All. And so this is a complicated issue. People are talking about increasing access to care, but from our own polling, we know that Medicare for All single payer might sound good to the public, but when the public hears about some of the trade-offs that may occur with this type of system, they're much less likely to support it because they like having access to their own provider. They like being able to go to their hospital, those sorts of trade-offs that might be occurring. And so all of this is really complicated, but to the public, to voters right now, what they are seeing is these costs that they are desperate for someone to address.

Larry Levitt: So let me come back. We've got a lot of questions about... Okay, so we're talking about lowering costs. How do we actually do that? I don't think we're going to solve that in the next 25 minutes of this discussion, but I want to come back to some of the questions raised by GLP-1s. And Sherry and Ben, both of you touched on this, and, Ben, you've written about this. So healthcare prices, I think we would all agree that healthcare prices are at the root of the affordability issue. I mean utilization of services as well, but prices at least explain why we spend so much more than other countries. And this issue of price gets at, well, what value are we getting for that high price? And how and when do we try to lower prices? So, Ben, I'll start with you. I think you would err on the side of market forces, competition to do that.

How successful might that be?

Benedic Ippolito: Yeah, I mean, the way I think about it is, look, the goal is not to, especially a commercial market, prices rule the day. That's what makes us different. But they're not all bad. We don't want to penalize people who are doing wonderful things. We don't want to penalize products or services that are incredibly cost-effective. The idea and the hope that whatever your approach is, the hope is to try and address the prices where we really think they're quite divorced from value. And you talk about markets. One of the reasons people tend to emphasize markets is when they function well, they tend to do a pretty good job of rewarding high value products and services and voting with their feet away from low value services. Part of the challenge with that approach in healthcare is obviously that some of these things are hard to observe.

Sometimes it's very hard to actually make choices. And so to what degree can you be successful? I think there's a genuine role for trying to make healthcare markets work as well as they possibly can. You want hospitals to compete with

each other. A hospital that doesn't have any competition lives a very privileged life. They don't need to make the same investments in quality and so on in the long run as one that really has to fight for patients, whether those patients come from Medicare or private insurance. There are limits obviously to the role of a pure competition-based model in healthcare. What are you going to do? And this gets to issues that Sherry mentioned earlier. What are you going to do in certain areas where they just aren't going to support multiple acute care hospitals? There's just not enough people around. You have to make a decision, and that decision reflects some normative values about how much you're willing to essentially subsidize certain areas versus others.

You also have to make decisions about what do you do in cases where you think that a market has, for example, consolidated so heavily that it's difficult to unwind. Are you going to let that hospital or healthcare system or insurance company or whatever it might be, behave as if it does not have any competitors? That I think is the harder bucket. I think these small markets that tend towards monopolies and so on is the easier bucket because it's not so expensive to solve that problem. But what do you do about the markets where there really isn't much competition? I do think there's an obvious role for regulation in those kind of cases, not to mention the fact that there's always going to be a role for regulation because of some of the nature of healthcare, emergency services, the lack of ability to choose and so on.

Larry Levitt: Sherry, how would you approach this?

Sherry Glied: So I actually think that Ben points out that there are a bunch of markets where it's unrealistic to expect competition to work, even if you are a real believer in competition. And competition has, I think, lots of values beyond whatever it does to prices. There's lots of good evidence just that it's really good for quality, but there are places where competition just is not going to happen. We talk about this, we've talked about it for a long time. We've done a really lousy job of coming up with alternative models. How should we be regulating hospitals in places where there is consolidation? What is the right way to set prices in those places?

There's remarkably little work on how to do that, and there's remarkably little interest in taking it on. So I think one of the things Ashley was talking about the big excitement around single payer, which has been around for... There's been a lot of excitement around this idea for a long time. And I think one of the frustrations I felt about it is that it's hard to think about what the incremental steps on the way are. One of the incremental steps is actually coming up with a system for regulating prices in places where you don't think markets work. And I'd love to see more action there because I feel like if you are a progressive person, being able to show that you can actually make things work with

regulated prices would be a really big step forward towards trying to get people more comfortable with this idea.

Benedic Ippolito: Some of these markets, pro-market type incentive ideas and regulation also, they're not so fundamentally distinct. We can think about trying to generate some of these competitive forces when we make regulations, when we, for example, decide how to subsidize markets. Right now we do something across almost all markets in the US where we essentially have the federal government subsidize healthcare in a relatively open-ended manner. Regardless of how high of costs go, the federal government continues to subsidize those costs. We can think about-

Larry Levitt: You're talking about the tax incentive for-

Benedic Ippolito: So I'm talking about basically all markets. So if you have employer-based coverage, whatever is contributed to your coverage is exempt from income taxation. Medicaid is also financed in a very open-ended way. However high Medicaid spending goes in a state, the federal government matches its share. The subsidies in the individual ACA market are tied to the prices of those plans. As the prices go up, these subsidies rise in lockstep. Medicare, a federally run program is more mechanically somewhat open-ended in that manner. And so you can think about the federal government or state governments subsidizing things relatively generously, but in a somewhat different fashion that tries to embrace, for example, some constraints on those subsidies in an effort to both balance providing that support while also trying to discipline the overall functionally the budget that that broader healthcare market has to work with. And so these things aren't totally distinct. I think it's important to keep in mind.

Sherry Glied: I guess part of it is also, I mean, I think where Ben and I might differ here is trying to figure out who can actually change those things. So how we discipline things, can individual Medicaid beneficiaries or Medicare beneficiaries make much of a difference in the costs that they face or are those costs really external to them? So some of this is about what is the role of government and which government in terms of trying to regulate some of these?

Benedic Ippolito: And who's responsible for trying to drive down costs? Is it the individual person in some cases? That may make a lot of sense. We often point to things like LASIK where this works awfully well. You can shop around.

Sherry Glied: Apparently not, but apparently-

Benedic Ippolito: Yeah. Well, okay. So a different, whatever Sherry's preferred version of this is, generic drugs, whatever it might be. But there's other cases where that's not the right agent. If you have employer-based coverage, I don't actually know that

I'm the right person to be figuring out the right network for my insurance plan, but I do want Aetna and United and Humana actually competing on these things and thinking about cost when they do it.

Larry Levitt: I mean, back to GLP-1s, a good example. I mean, most people did not have coverage for GLP-1s. The price came down rapidly, but still to a point where it was out of reach for probably most people to pay out of pocket to address obesity. So the markets can work but can't necessarily truly make it affordable for folks. So we've had a number of questions about AI. I don't think we can avoid any conversation about anything without talking about AI. So think about how to ask this. So you both talked about this period we've been in with remarkably low healthcare inflation, stabilizing at roughly 17% of GDP. Now AI comes onto the scene. What is that going to mean? Does that have the potential to make things more efficient, bring costs down even further, or does it have the potential to accelerate things as technologies generally do in healthcare?

Sherry Glied: So I don't know the answer, and I hate prognosticating, but I guess the thing about AI is at this point it doesn't actually change what healthcare can do for you. So the times when healthcare technologies have actually increased costs have usually been when you've essentially expanded the basket of things that's inside healthcare. Take GLP-1s. We now have a treatment for something we didn't have a treatment before. If I look back to my 1927 folks, there was nothing healthcare could do for you. The expansion in cost has come because we can do stuff. I don't know that AI is actually going to change what healthcare can do for you. So is it going to actually lead to an increase in the demand for healthcare in the sense that GLP-1s actually lead to an increase in the demand for healthcare because there is something new it can do?

And in that sense, I'm a little more optimistic that it will bring costs down eventually after all the games with coding and all that stuff happen. In the short run, who knows? In the short run, it will drive costs up.

Benedic Ippolito: Yeah, I think the long run case for increasing health costs is something like early stage drug developers use AI to try and identify promising compounds, and that leads to an uptick in eventual approvals for high value drugs and that we got a new wave of GLP-1s or whatever it might be. So that's a genuine possibility. In the near term, I will simply say I have not heard a very compelling case for lowering costs. I have certainly seen the most obvious application of AI in insure coding battles and battles between insurers and providers in terms of coding and billing and things like that, which doesn't really seem like a welfare improving exercise for the society writ large.

Sherry Glied: It might allow us to go further in expanding the range of things that less costly providers can do. So in that way, if you can expand the way that we use alternative providers and maybe do better allocation of cases between alternative non-physician providers and physicians, we've seen that has been a component of the slowdown in healthcare cost growth that could extend.

Ashley Kirzinger: Well, and on the public side, it is reducing their healthcare costs because the public is relying on AI instead of going to their provider. And I'm not saying that that is a positive thing, but it is as healthcare costs, as a visit to the provider costs more and more out of pocket individuals are looking for alternative ways, and AI is filling that gap for lots of individuals.

Larry Levitt: And we know that for sure. I mean, we've actually found that in our polling, right, Ashley?

Ashley Kirzinger: Yeah, absolutely. And we ask people why they turn to AI for health information, and they tell us it's because of costs.

Sherry Glied: Although I doubt that honestly, right? Don't we all turn to AI for everything now?

Ashley Kirzinger: I mean, we may turn to AI even if it's intentional or not, but I do think people that don't have a regular provider, I do think that maybe it's one of the main reasons why they go. We ask people, okay, you found you went to AI, did you then follow up with a provider? And those people are the ones that tell us, "Okay, I didn't because of costs." Right?

Sherry Glied: Okay, fair enough. I think we're all typing our symptoms into ChatGPT though.

Ashley Kirzinger: Which I'm not saying is the right thing.

Sherry Glied: I'm not saying it's the right thing. I'm just saying it's happening.

Larry Levitt: So we use the word cost in healthcare loosely, and we have all done it in this conversation as well. And I think we mean it as cost to whom? Cost to a patient, cost to an employer, cost to government. But we don't talk a lot about the underlying costs in a hospital system, let's say. So, for example, if AI allows hospitals to upcode and get more money from insurance companies, their costs don't necessarily change, but the cost of the insurance company and patients does, which gets at some of the questions we've been getting around profits in health systems or insurers or CEO salaries. Back to where Ben started with the cost drivers, the macro cost drivers, how much is that part of the story, profit margins, administrative costs, CEO salaries?

Benedic Ippolito: Sherry, I'll go. I'll take a stab.

Larry Levitt: Yeah, why don't you start, Ben.

Benedic Ippolito: I mean, look, these things are material. I will admit I spend approximately zero times worrying about executive salaries just because in the grand scheme of things it's basically trivial, even though I understand the political and beyond component. In terms of how big is this? First, I do think it's very important to keep in mind you don't want no administrative costs, and you don't want no profits. These things are important. Administrative costs, for example, are very important for policing use of very low value care that might be expensive. That type of thing is a valuable use of administrative costs. Where I worry about this stuff is generally speaking in markets where we think the competitive dynamics are fading or are very low. That's where I worry about excess profits. But really what I worry about in those markets is just that it's a very low value use of federal or individuals' monies.

I worry less about the profits per se and that we have an area where, for example, we have much higher spending, much higher prices, but we're getting roughly the same thing as we're getting in a much lower cost area. And so I almost think the competitive dynamics are the fundamental thing that I worry about. And one of the ways that manifests is unusually high profit margins and so on in certain markets.

Larry Levitt: And Sherry do you think about this?

Sherry Glied: Look, it would be nice if all of this costs less, but it wouldn't make very much difference to the basic affordability problem that we are all facing.

If you could pull 5%, 10% out of the system, wouldn't that be wonderful? But that isn't really going to change the answers that Ashley is getting in her surveys. And that doesn't mean we shouldn't think about it. It doesn't mean that we shouldn't be careful about it. I worry about how we measure these things. We have this huge not-for-profit hospital system in the United States where nobody's supposed to be making a profit and they aren't making a profit. Mostly their margins are zero or negative or something. But what does that exactly mean? I don't know. We run our system with a lot of inherent costs to it, and that's part of it.

Larry Levitt: Yeah. And I mean a hospital's costs are not some law of nature, right?

Sherry Glied: Right.

Larry Levitt: If a hospital is getting revenue, they will find a way to spend that revenue.

Sherry Glied: A really interesting thing I've been obsessing about lately is that the new norm in the United States I think required by the Joint Commission is that new hospitals have single-bedded rooms with individual bathrooms. That is not the norm in the rest of the world, not at all. And it's going to show up in our costs, and we won't be able to point at anything in particular, but you'll need more janitors, right?

Benedic Ippolito: Well, you also see evidence to this point about costs are not, we would say they're endogenous. The hospital has some say over what costs are, especially in the medium and longer run. And we also see that, and it informs these broader conversations about the right price and so on, where if you look at hospitals that predominantly treat Medicaid and Medicare patients that tend to pay lower prices, they do have materially lower costs than the hospitals that really try to attract much higher paying commercial privately insured patients. And so we can learn something from essentially ask the question, well, what does the quality look like at those hospitals that have a lot of public pay patients? Is that acceptable?

Sherry Glied: And one of the things that's really interesting actually, if you go there is that the correlation between the hospital's costs and its quality is not as high as you would think it should be. There are lots of markets in which you have very high cost hospitals that are not producing high quality care. They're essentially wasting their resources. This actually also raises a question on the compensation of the non-physician providers. There's lots of evidence now that the quality of management in hospitals matters a lot. And there are some very good low cost safety net hospitals that are just really managed well.

Benedic Ippolito: Or it says those high-priced hospitals, part of what we're doing by really juicing these commercial markets with quite heavily subsidized purchasers is that they're spending money on things to attract people that are just not related to patient care. It's the stuff that is nice to have. The facilities look nice. All the rooms are set... Well, now it sounds like I guess that's a requirement. All the rooms are separate. You have a lot of space in the rooms and so on. Those might be nice to have things that a very high willingness to pay person might value. But in terms of generating quality that one might look at as a regulator or whatever, that's probably not really moving the needle very much at all.

Larry Levitt: So I want to bring this back up. We're approaching the end of our time. So let me bring this back to the campaign. Affordability is an issue in this campaign. And, Ashley, let me start with you. We know voters see this as a problem. How would you characterize what voters are looking for candidates to talk about?

Ashley Kirzinger: It's really partisan. So I mean I think across the aisle, the political aisle, Republicans, Democrats, Independents want candidates to be talking about

affordability, agreeing that affordability is an issue and coming up with some talking points to address affordability. For Democrats, that's a lot around lowering individual healthcare costs. For Republicans, it's addressing fraud in government health programs. They see that as a way to address the high healthcare costs. And across the aisles, it's addressing the cost of prescription drugs. So we're going to be seeing candidates talking a lot about prescription drug costs over the next several months as well.

Larry Levitt: And Sherry and Ben, imagine a candidate comes to you, and I imagine candidates have come to you and asked you what's one idea for addressing affordability? Sherry, I'll start with you.

Sherry Glied: So I think we have, for a variety of reasons, really shifted the burden of healthcare costs towards sicker people over the last 15 or 20 years. The rise of high deductible plans and other things has really meant that if really bad things happen to you, you are out more than would've been the case in the past. And I think we could without actually incurring enormous costs make a promise to people that they would not have to spend more than some amount of money in total on their healthcare. I think working out the details of that is complicated, but we can do it. There are strategies I think that we can use to do it. And I think really protecting people from those catastrophic expenses is critical, especially since under the Affordable Care Act, preventive services are now already available to people without cost sharing. So providing that protection at the high end is where I would put my two cents.

Larry Levitt: And, Ben, a candidate comes to you, probably a different candidate than might come to Sherry and ask you what's the one thing you would suggest they advocate?

Benedic Ippolito: Maybe I'd say the same thing. I like Sherry's answer, which is that really your first principle is protect people from huge financial shocks. That is the first goal I think of this whole exercise and then some baseline access to care. And so I think, especially in the non-Medicaid world, really thinking about, okay, where's an upper limit, and what can we plausibly agree on? I try to build on, I know it gets derided, but the waste fraud and abuse framing is silly in some ways because I think it emphasizes more of the true fraud. But this idea that there's a lot of room to really tighten up what the federal government in particular is doing and how it purchases healthcare, that is genuinely important. Medicare Advantage, there's a lot of money to save. There's a lot of money to save by being a little bit smarter about how we subsidize healthcare writ large.

And that's not a huge hammer that hits today, but that frees up so much money in the long run that you generate something to play with where you can generate some savings for the country writ large, but also deliver some of the

kinds of things that Sherry are talking about. Reform Medicare Advantage, employer subsidies and so on, and use some of that money to really firmly try and limit total exposure. That kind of package strikes me as something that balances two very important goals.

Sherry Glied: I totally agree with Ben. Go after the fraud, the provider fraud, that's where the money is. That's where we should be really tightening things up and the MA fraud. But I do worry that the fraud conversation winds up being about individuals. And I do want to emphasize that probably the most important thing that we need to do is to make sure that we keep those uninsurance rates down. We're about to see a big spike in them, and people who are uninsured have no financial protection against their out-of-pocket costs. And some of them are low income, and they're going to wind up with care that's provided by other publicly funded sources, but a lot of them are going to go without care, and a lot of them are going to wind up in really bad financial circumstances. So I also just want to make sure I put that in there.

Larry Levitt: We have talked a lot about affordability for people with insurance. We haven't talked a lot about the fact that as you said, Sherry, people without insurance have no meaningful protection at all, and that number is going to go up.

Well, I think we've achieved a small element of bipartisanship here in the Wonk Shop corner of the world, which is productive. Thanks to three of you. Thanks Ben, Sherry, and Ashley for a great discussion. Thanks to the audience for watching and for the great questions as well. And join us next time on The Wonk Shop.