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My name is Katherine Baicker, and I am Dean of the Harris School of Public Policy at the University of Chicago and a health economics researcher. I would like to thank Senator Johnson, Senator McCaskill, and the Distinguished Members of the Committee for giving me the opportunity to speak today about the current landscape of the U.S. health care system.

We devote $3.2 trillion to health care annually.[1] We spend substantially more per capita than other countries – and substantially more in some parts of our country than others – without commensurate improvements in health outcomes. For example, areas of the country where we spend the most on Medicare beneficiaries' care are areas where they are less likely to get some types of high-quality, high-value care.[2]

Fundamentally, the key challenge in our health care system is not how much we spend per se, but that we are not getting the valuable health improvements that we should for each dollar that we do spend. The quantity and value of the care that we get is driven by the way that we pay for it – both the cost-sharing that patients face and the payment system that reimburses providers.

Where Does the Money Come From?

The way that we purchase health care, as patients and insurance enrollees, has changed dramatically in the last 50 years – and in some surprising ways. Through the advent and expansion of Medicare and Medicaid, the rise of employer-sponsored insurance, and the introduction of subsidized non-group insurance plans, the number of uninsured Americans has dropped substantially. The share of Americans who are uninsured declined from about 15% in 1994 to about 9% in 2015 (see Figure 1). Insurance provides vital benefits for enrollees, but also affects the quantity and value of the care we use.

Beyond access to care, insurance coverage provides crucial financial protection against the unfortunate circumstance of falling ill – the key characteristic of insurance (regardless of how it is financed). Subsidized "social insurance" can also redistribute resources from rich to poor, or from those who are healthy to those who are known to be sick. Private insurance can spread the risk of uncertain future needs, but fundamentally does not redistribute resources in the way that social insurance can.[3]

People are markedly better off being insured than being uninsured: they have better health outcomes and more financial security.[4-6] But insurance changes the quantity and nature of care that patients consume, and how that insurance is designed can determine whether health and financial benefits are gained efficiently or at a cost that is too high. This is because patients' cost-sharing has a marked effect on the care they use.

There has been a notable, consistent decline in the share of health care that is purchased "out of pocket," versus through a public or private insurance plan (see Figure 2). Health insurance does not look like most other kinds of insurance we buy – like renter's, homeowner's, or car insurance, which typically have substantial deductibles and do not cover routine expenses – but rather includes a substantial "prepaid health care" component, covering routine care that does not carry the kind of financial risk that insurance is normally designed to address. This is in large part because of the tax preference for employer-sponsored insurance (versus out-of-pocket purchases), alongside the structure of our public insurance programs. Insurance has also evolved as the main channel for patients to get discounted prices from providers.

The broad decline seen in aggregate cost-sharing runs counter to public discourse about the rise in high-deductible plans and increases in cost-sharing. This disconnect may arise from the fact that a greater share of the population is now covered by plans with very limited cost-sharing (e.g. Medicaid, ubiquitous supplemental Medicare coverage), while there has been a rise in cost-sharing in many commercial plans. For example, the share of employees in plans with deductibles of $1,000 or more has increased from about 10% in 2006 to 51% in 2016, at the same time that the share covered by Medicaid has risen from about 13% to 20%.[7,8]

What is the "right" level of cost-sharing? At first blush, it might seem that cost-sharing is just a way of dividing up whether insurers or enrollees pay the bills, but decades of evidence shows that lower cost-sharing leads patients to consume more care of limited health benefit – such as unnecessary tests – and that this inefficient use leads to higher premiums.[9-11] Insurance that covers too much care with too little cost-sharing can lead beneficiaries to consume care of diminishing value, which raises costs overall. The idea that someone could have "too much insurance" may not be intuitive, but there is a fundamental trade-off between the financial protection afforded by insurance and the cost of the higher utilization that insurance induces: too little cost-sharing means patients have no incentive to spend health care dollars wisely; too much cost-sharing means that a policy fails to perform its insurance function.[12]

Many criticisms of higher cost-sharing in employer plans are based on the presumption that it is possible to have high wages, lower premiums, and lower cost-sharing, but the three are intertwined. The employee share of premiums has been fairly stable between 25 and 30 percent for the last two decades.[7] This is difficult to observe for most employees. More important – but even less transparent – is the fact that employees ultimately pay both the employee and the employer shares, because when the cost of health insurance rises, less money is available for wages.[3,13,14] This wage-fringe trade-off does not occur instantaneously for each individual, but in the long-run employees pay for the full cost of health insurance premiums through lower wages or lower employment. The tax preference for employer health insurance also pushes people into more expensive plans with lower copays – which is both regressive (the biggest benefits go to those with the highest income) and inefficient (artificially low cost-sharing leads to greater use of care with questionable benefit, driving premiums up and wages down). There is also very little cost-sharing in many public policies.

There has been some experimentation with innovative insurance coverage, basing cost-sharing on the value of care in improving health.[15-17] Some experiments involve sharing the savings with patients who choose lower cost, high-quality options.[18-20] For such measures to be effective, patients need transparent information about the price of the care they are using – although transparency alone may not be sufficient if information does not reach patients at the right time and from by a trusted source.[21] Of course, patients need choices among competing insurers (as

well as providers) to spur innovation and lower costs. In areas where there are fewer insurers, premiums tend to be higher.[22,23]

Where Does the Money Go?

Alongside how patients pay for care, health care spending is driven by the way that providers are reimbursed for the care they deliver. The categories of care on which we spend by far the most are hospitals and physician services (see Figure 3). Although some other categories of spending are rising more rapidly, these still comprise the lion's share of health care spending – both overall and within different insurance market segments. This highlights the centrality of these particular services to health care spending overall.

Like patients, providers also respond to the payment system.[24,25] We get more of the services that are generously reimbursed, and fewer of the services that are paid less well. The traditional fee-for-service reimbursement system still covers the majority of Medicare enrollees, basing payments on the quantity of care delivered rather than the quality or value of that care. Furthermore, Medicare's payment structure and utilization patterns can drive spending throughout the health care system.[26,27]

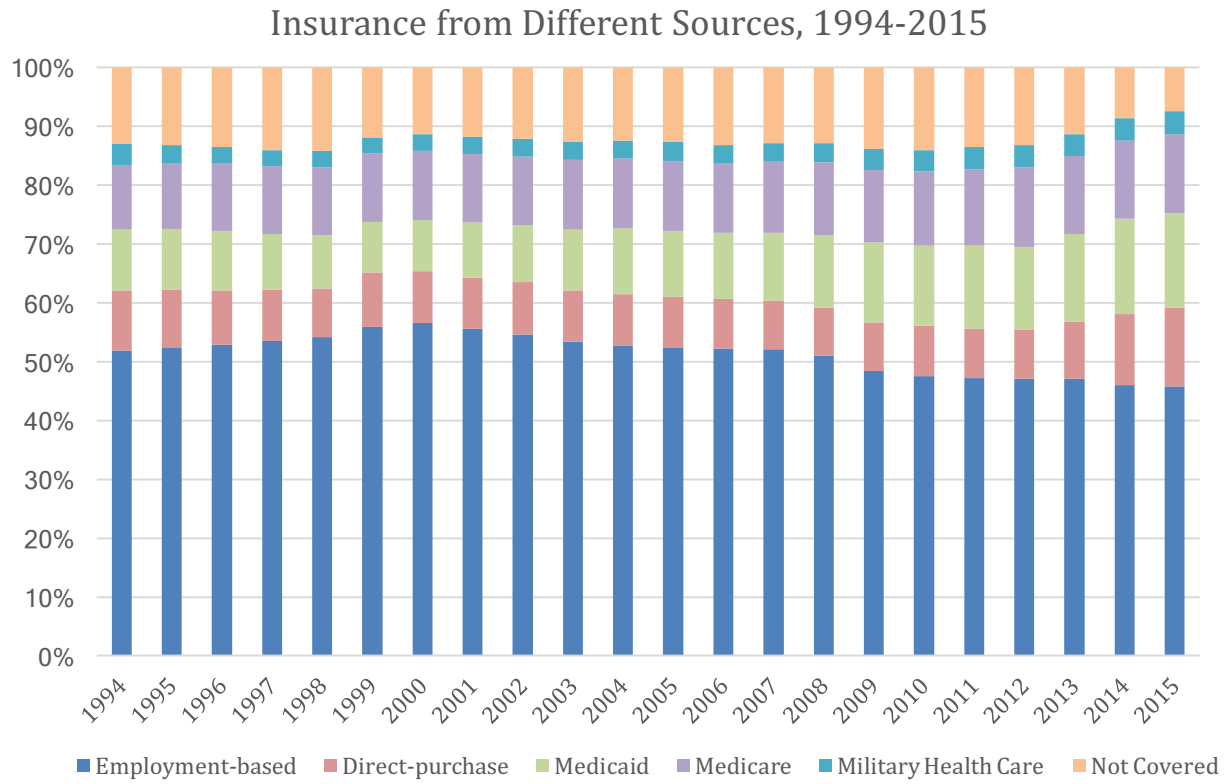
There has been experimentation by private insurers with "value-based" payments and accountable care organizations, along with alternative payment models introduced in Medicare's payment schedule for physicians and other services.[15,28-30] These alternative payment systems aim to generate an incentive for physicians to play an active role in managing the cost of their patients' care – vital given the central role that physicians and other health care providers play in helping their patients make informed decisions. Having adequate risk adjustment and quality monitoring are crucial to such systems working effectively to improve both value and quality. Financial incentives for providers to increase value delivered to patients – rather than just quantity – are also more likely to be effective when there is robust competition among providers. Analogous to insurer competition, in areas where there are fewer providers for patients to choose among, provider prices tend to be higher.[31,32]

The Central Role of Health Care Financing

The way that we finance health care is a key determinant of the current landscape of health care spending. With about 18% of GDP devoted to health care spending, it is crucial that we get as much health as we can in the most efficient way possible from our health care system.[33] Health insurance provides vital financial protection and access to care, but can also lead to inefficient use of health care resources. A close examination of the way that health care financing drives both spending and how the burden of that spending is shared can lay the foundation for a high-value, sustainable health care system.

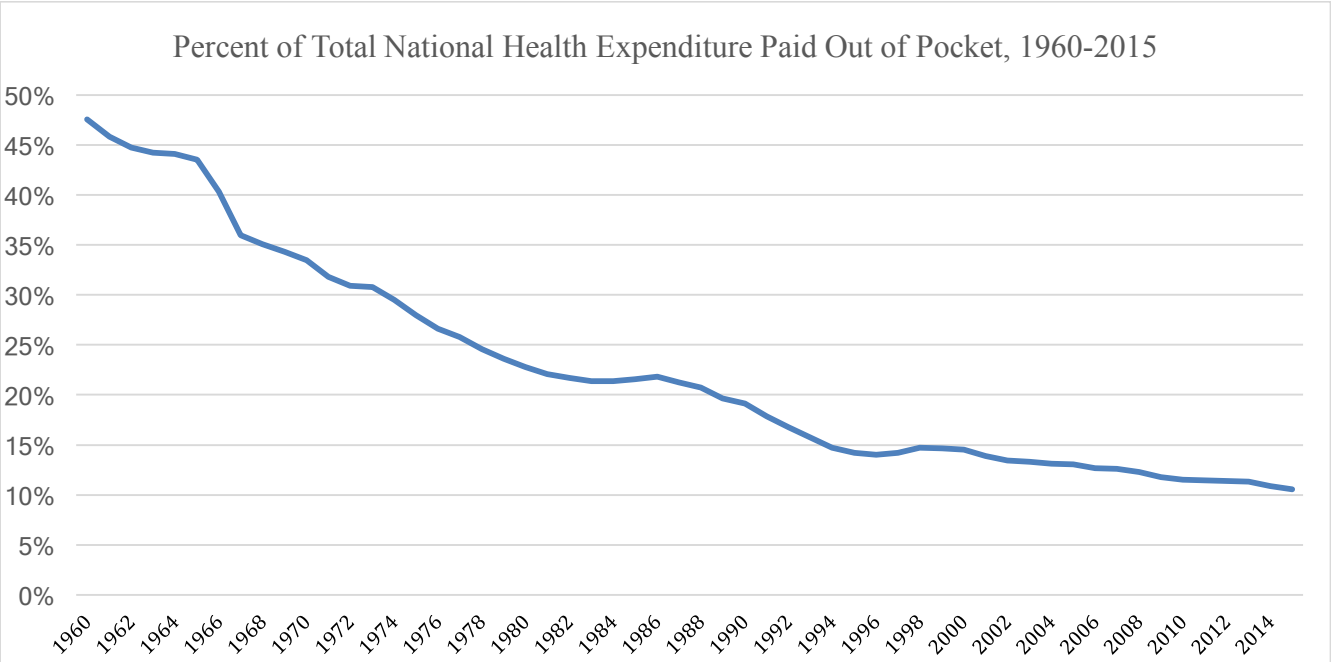
FIGURES

Figure 1



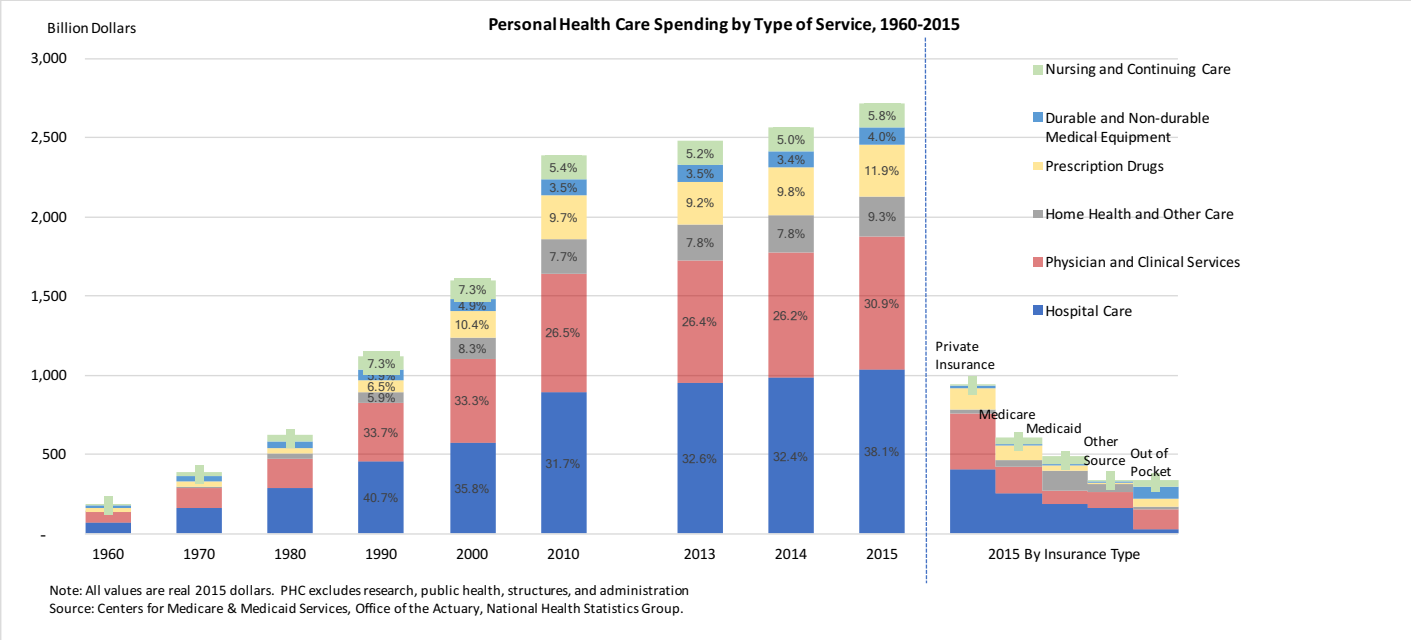
Note: The types of insurance are not mutually exclusive; people may be covered by more than one during the year.
Source: U.S. Census Bureau, Current Population Survey, 1995 to 2016 Annual Social and Economic Supplements

Figure 2



Note: Out of Pocket includes co-payments, deductibles, and any amount paid that was not covered by health insurance.
Source: National Health Expenditures Tables, Centers for Medicare & Medicaid, Office of the Actuary, National Health Statistics

Figure 3



Note: All values are real 2015 dollars. PHC excludes research, public health, structures, and administration
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

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