The Health Care Blog

Misdiagnosis: Obamacare Tried to Fix the Wrong Things and Prescribed the Wrong Treatments

Charles Silver and David A. Hyman

June 19, 2018

There are many reasons why the United States is "the most expensive place in the world to get sick." In Part 1 of *Overcharged: Why Americans Pay Too Much For Health Care*, we show that the main reason is that we pay for medical treatments the wrong way. Instead of having consumers purchase these treatments directly, we route trillions of dollars through third-parties payers – both government and private insurers.

Relying on third party payers has many consequences — few of them good. To start with, this arrangement removes the budgetary constraint that would otherwise cap the amount consumers are willing to spend. By minimizing the direct cost of treatments at the point of sale, third party payment arrangements alter everyone's incentives fundamentally. Consumers no longer need worry about balancing marginal costs against marginal benefits; instead, they have an incentive to use all treatments that have any potential to help, regardless of their prices. When millions of consumers act on these incentives, total spending skyrockets and consumers collectively wind up worse off, because their fixed costs spiral upward too. Heavy reliance on third party payers creates a classic failure of collective action.

It isn't just consumers. Providers love third party payment as well. And why not? Once providers have access to the enormous bank accounts of third party payers, the sky is the limit, at least until third party payers start setting limits on the amounts they will pay and saying no to unproven and/or cost-ineffective treatments that doctors want to provide and patients want to receive.

Not surprisingly, it has turned out to be extraordinarily difficult and politically unpopular for third party payers to set such limits. Obamacare's appeal derives largely from two requirements: health insurance plans must accept all comers, including applicants with preexisting conditions that require expensive medical treatments; and health plans must provide unlimited benefits (i.e., no annual or lifetime spending caps). From an individual consumer's perspective, what could be better than having access to unlimited amounts of money to spend on medical needs? From society's point of view, though, this combination is a recipe for disaster.

Medicare hasn't been able to do much about this problem either. In Medicare Part B, the program simply pays whatever price the drug companies ask – even if the treatments offer only marginal benefits over existing (and far cheaper) treatments. Medicare Part D is better, since private plans can use formularies to create competition among drug manufacturers. But even

here, there are limits, since plans are required to cover all drugs in six "protected" classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.

Why is Medicare such a patsy when it comes to drug prices? Politics. If CMS were to refuse to pay for an effective medication because of its price, cries of rationing—the third rail of health politics—would quickly fill the air. The AARP would pack the halls of Congress with seniors in wheelchairs, drug makers and the AMA would send in hundreds of lobbyists and doctors in white coats, and pandering politicians would inundate CMS with demands to pay for the drug. Knowing full well how this scenario would play out, no head of CMS who wanted to hold onto the job would risk incurring the backlash in the first place.

Private insurers haven't done much better. In fact, there is an emerging consensus that private insurers don't care about prices nearly as much as they should. "Widely perceived as fierce guardians of health care dollars, insurers, in many cases, aren't. In fact, they often agree to pay high prices, then, one way or another, pass those high prices on to patients — all while raking in healthy profits."

The main problem with our health care system is that the prices are too damned high. Consider the conclusion of a well-known study published in Health Affairs in 2003:

In 2000 the United States spent considerably more on health care than any other country, whether measured per capita or as a percentage of GDP. At the same time, most measures of aggregate utilization such as physician visits per capita and hospital days per capita were below the OECD median. Since spending is a product of both the goods and services used and their prices, this implies that much higher prices are paid in the United States than in other countries. But U.S. policymakers need to reflect on what Americans are getting for their greater health spending. They could conclude: It's the prices, stupid.

In case anyone missed the point, the same authors published a follow-up paper in 2004, entitled "It's The Prices, Stupid: Why The United States Is So Different From Other Countries."

A decade later, little had changed. That's when the late Uwe Reinhardt, one of the authors of the two studies already mentioned, wrote a column entitled "U.S. Health Care Prices Are the Elephant in the Room." Additional confirmation arrived in 2018, when JAMA published a studyfinding that "Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries." If third party payers had been doing a good job of controlling prices, none of these publications would have been written.

Part 1 of *Overcharged* documents the real-world consequences of our third-party payment system. For example, Chapter 2, focuses on the prices drug makers charge for new medications. When the sky is the limit, pharma companies maximize their profits by developing new medications on which they hold monopolies and by charging absurd amounts. Often, these medications confer minimal benefits. "The 72 cancer therapies approved from 2002 through 2014 gave patients only 2.1 more months of life than older drugs," but 11 of the 12 approved in

2012 were priced above $100,000 per course of treatment. The tally was even higher in 2016, when the approved drugs cost an average of $171,000 a year. "Although the high prices can lead patients to think they're getting the Mercedes of cancer drugs, research shows that a medication's price has no relationship to how well it works." The situation is so bad that "[a] group of academic researchers has demanded an end to cancer medicines costing more than $100,000 a year."

By comparison to the prices being demanded for the new CAR T-cell cancer treatments, $100,000 seems like a bargain. Novartis set Kymriah's price at $475,000, a level that, in the words of Dr. Leonard Saltz, chief of gastrointestinal oncology at Memorial Sloan Kettering Cancer Center in New York, "shattered oncology drug pricing norms." And that's just the price of the drug. Kymriah requires lengthy hospital stays and can have serious side effects, including immune system reactions, stroke-like symptoms, and coma. Some patients who receive it need bone marrow transplants and other expensive procedures. The total cost per patient could reach $1.5 million. With 21 other CAR T-cell treatments currently under development, the cost of treating cancer patients seems bound to increase.

What's true for cancer treatments is also true for other specialty drugs. "[S]pecialty drugs account for less than 2 percent of all prescriptions, [but] they make up roughly 30 percent of spending on all prescription drugs." "That is projected to grow to 50% in 2017, according to Express Scripts, the pharmacy benefits manager." The growing number of high-priced specialty drugs is a primary reason that total spending on prescription drugs is expected to exceed $590 billion by 2020, up from $337 billion in 2015.

The absence of a ceiling on prices is a serious problem, but it is far from the only pathology caused by our heavy reliance on third-party payers. There is also the gaming of payment rules, quality indifference, waste, and fraud. Part 1 delves into these consequences in nauseating detail. One reader, a well-known health economist, told us that, after finishing this part of the book, he felt like he needed a shower. Another health economist complained the book made him depressed about his career choice. When even practitioners of the dismal science find the stories and statistics overwhelming, it is clear that the problems we document are pervasive and severe.

Many knowledgeable observers believe that something on the order of one-third of dollars spent on health care are wasted. Donald Berwick and Andrew Hackbarth offered a mid-point estimate of the 2011 cost of waste to the U.S. health care system of $910 billion, with an upper bound of $1.263 trillion. Paul Keckley and coauthors reached a similar conclusion in 2015. And as health care spending continues to grow, the number of wasted dollars does too.

Why so much waste? Because our third-party-dominated payment system corrupts everyone's incentives. As explained previously, consumers care about neither costs nor the ratio of marginal cost to marginal benefit. Providers gain by maximizing their billings, which they do using multiple schemes. Many are illegitimate and inappropriate. Some expose patients to unwarranted risks. Payers have neither the incentive to ferret out waste nor the resources that a serious undertaking would require.

Put simply, third-party payment creates an enormous need for monitoring because the incentive—always present in first-party arrangements—to demand value for the dollar is lost. This monitoring problem has never been solved, and never will be solved, because the health care sector is too large to be policed. It is easier for payers to recoup dollars lost to fraud, waste, and abuse by raising premiums and collecting higher tax revenues than it is to keep providers and patients honest.

The lack of a price ceiling and the extraordinary sums lost to waste are the problems that Obamacare should have tried to fix. Unfortunately, it didn't address either. Instead, it made both problems considerably worse. The Medicaid expansion and the new insurance rules brought tens of millions of new people under the comprehensive third-party payment umbrella.

Therein lies the problem. Most mainstream health policy analysts believe that the biggest problem in health care today is that millions of people are uninsured. A large fraction of the population, especially voters who identify as Democrats, feels the same way. For both groups, the preferred solution is more and more comprehensive insurance. The large and growing base of support for Senator Bernie Sanders' Medicare-for-All proposal reflects this belief. But it should be obvious that our heavy reliance on third-party payment arrangements is the major driver of our health care cost crisis.

Third-party payment is the disease, not the cure. This will be no prospect of reducing health care spending until this point is understood.

Charlie Silver holds a Chair in Civil Procedure at the School of Law, University of Texas at Austin. David A. Hyman is Professor of Law at the Georgetown Law Center. They are both Adjunct Scholars at the Cato Institute.