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Health Care Affordability

Expert Insights

At Penn LDI's March 2026 convening at Penn Washington, leading experts Brian Blase, Zeke Emanuel, Michael Anne Kyle, Aaron Schwartz, Zack Cooper, and Leemore Dafny found notable consensus on the drivers of health care costs, and some potential paths forward. Below are the panelists insights, in their own words. Explore the full recap here.

1 PROBLEM → Hospital Costs

Blase: Hospital prices have been the fastest-growing part of the economy. They've risen three times faster than inflation and twice the rate of wage growth since the turn of the century.

Emanuel: Hospitals have to be your main focus. They are a third of spending, even as the amount of volume going through them is going down.

Cooper: I'd argue [policymakers are] probably not spending the bulk of your time thinking about hospital spending and hospital pricing…That's where your efforts should focus. Why?…The prices in the hospital sector have gone up faster than prices in any other sector of the economy.

POTENTIAL SOLUTIONS

Site Neutral Payment in Medicare

Dafny: Medicare pays much more for care that is delivered in a hospital-affiliated site. Even if it's just like an office practice that happened to be purchased by a hospital…We would not just save a lot of money if we did this [payment] neutralization, we would remove the incentive for hospitals to expand so much.

Price Regulation

Emanuel: I would start capping hospital prices and making that cap flexible with how concentrated they are in the market.

Cooper: Sort of the elephant in the room is that all of the proposals that really do lead to substantial savings involve some form of price regulation, either implicitly or explicitly…It sort of makes the hairs on the back of my neck stand up to talk about regulated prices…We are one of the only countries that doesn't. And the parts of the US health system that are affordable do. At some point, we may need to engage with that pretty seriously.

Dafny: There are also some markets that are already so consolidated that we're not going to successfully unscramble [them]...We really needed to think hard about provider price caps. This is not the same thing as setting prices for all hospitals. This is…setting a price ceiling for hospitals.

Blase: I think we need to take power out of CMS. CMS sets prices throughout the entire health sector. We run our health care system off of price controls set by a bureaucracy.

Global Budgets

Emanuel: We do need a total budget on health care…and re-examine this budget over time. We just can't do it once and then walk away. We have to have a budget for hospital[s] and a budget for primary care, and a budget for specialists…and one of the reasons for separating that out [is so] you don't get the specialist or the hospital taking money away from primary care docs. Germany does this…a big slug of money is given to the AMA equivalent in Germany, and they pay doctors out of that… If the specialists go over the limit, which is invariably the case, they get paid less, and it doesn't threaten primary care.

Blase: I agree with a lot of that. I think there should definitely be budgets on government health programs.

Reference Pricing

Blase: Reference pricing [is]…where the plan pays up to a certain amount, and anything above that amount the individual consumer would pay. That's what we saw in California…They set the reference price at about the 65th percentile. That means you could go to 65% of providers and pay nothing out of pocket. What happened was consumers did start shopping. They started taking their business away from high-priced providers to low-priced providers. Then…the high priced providers lowered their prices. Average price reductions of 20%.

Emanuel: Look, I love reference pricing. I think it does work when it's not the consumer doing the work.

2 PROBLEM → Consolidation

Cooper: What most research shows is that when hospitals that are close substitutes merge, prices go up 5, 10, 20, even 30%...If a hospital is a monopoly, you cannot be hoping to get a competitively determined rate in those markets. That's why we see things like monopoly hospitals having prices that are about 15% higher than hospitals [with] competitors.

Cooper: When health spending goes up…payroll in companies outside the health care sector goes down, jobs get lost. The job losses are concentrated among workers earning less than $100,000 a year…Rising health care spending in the presence of employer-sponsored health insurance is a leading driver of income inequality in the US, and we see that a dollar increase in health care spending is taking out $1.33 for the rest of the economy.

POTENTIAL SOLUTIONS

Anti-Trust Tools

Emanuel: We have to make [hospitals] have a lot of acid indigestion and want to disgorge all the mergers that they've done.

Dafny: We could increase the budget [of antitrust agencies]. The number of [consolidation] transactions reported to the government increased by 80% between 2010 and 2018, but the budget [for enforcement agencies] decreased by 47% in real terms.

Dafny: Trying to obtain a divestiture after a transaction has closed is like unscrambling eggs…authorities need to have the information before the transaction goes through in order to prevent potentially anti-competitive ones. We could require more notice…[and we could] amend our federal antitrust enforcement statutes to change some of the strong language around what our authorities can challenge.

3 PROBLEM → Lack of Transparency, Lack of Consumer Shopping

Emanuel: [When people] shop for insurance…they typically shop on only one thing, which is premium. People spend less than an hour, and the more choices they have, the more detail they need to look into, the less they focus on it, and the more they just make an irrational choice. You know, you got more than four choices…you make bigger mistakes that cost you more.

POTENTIAL SOLUTIONS

Price Transparency Requirements

Emanuel: Price transparency has never worked to control costs. Never, ever…No one wants to spend a lot of time figuring out what the price is. And they just want to get the service. Health care is a grudge activity. People don't love to go to the doctor or go to the hospital. They don't want to spend more time. And that's all transparency requires is more time.

Blase: I agree, but I think the big benefit from transparency, in my view, goes to the employers. Employers shop for health care, they hire insurance companies to do the negotiation and set up the plan design. This gives them a way to monitor the insurers that they've hired…Why do we trust people to shop in other areas of their life and not in health care?

Emanuel: Because in other areas…shopping is not a grudge activity…I am an oncologist. I've never heard someone say where is the cheapest oncology care. They always ask me where's the best oncology care.

Blase: Health Savings Accounts are a useful financial tool. [But] they have limits. It does help grow wealth over time, which you can use for health care expenses. But for really high cost procedures, you're going to blow through your HSA.

4 PROBLEM → Fragmentation and Complexity

Emanuel: One of the most important perverse incentives is the result of fragmentation: fragmentation on coverage, fragmentation on payment, fragmentation on every other part of the system, and therefore lack of standardization, lack of simplification in the system…When insurers negotiate on behalf of employers, they do a miserable job because it's so fragmented.

Kyle: There is [a] decision point where you have got to say, what are we going to cover? For whom and how much are we going to pay for it?...In other countries, they do it in a more centralized way than we do it. We're very uncomfortable with that politically. And as a result, we do [these decisions] prescription by prescription. And that's why we have so much utilization management.

Kyle: For decades, we've asked people about delayed and foregone care because it was unaffordable. I took the same question structure and asked them about administrative work instead of costs. Three of four Medicare beneficiaries had a challenge with an administrative task in the past 12 months, and 30% reported delayed or foregone care. And of that [group], over half of them said they had a health consequence because of that delayed or foregone care.

POTENTIAL SOLUTIONS

A Model of Simplified Coverage

Emanuel: I think you need to have only two ways of getting insurance in this country. One way is your employer gives you insurance and we leave it to them if they want to stay in the market…The other way is you've got a public program. You have one exchange for everyone [else]: Medicare, Medicaid, the exchange, the uninsured…Second, in that exchange, you need a limited number of choices. Those limited number of choices includes traditional Medicare and then five or so insurance options on a standardized platform. Standardized benefits…That's a separate public exchange that would have 110 million Americans.

Blase: I'm intrigued by the idea of a single marketplace.

Kyle: On my wish list to alleviate administrative burden: Standardization! Of forms, jargon, processes.

Blase: I am not in favor of standardization. I think standardization means the government is going to pick what it thinks is best and impose that on everybody, and people are very different.

Insurance Coverage Periods Lasting Longer Than a Year

Emanuel: Churn is a huge problem in our system…especially if you're interested in prevention...The insurance compan[ies] have shown zero interest in prevention unless you mandate it and they have to do it and part of the main reason is churn. So you need longer-term timeframes…You need five-year contracts…that also [would] dramatically change how insurance companies manage those patients.

Blase: I agree with long-term contracts. The Trump administration has a proposal…to go to a ten-year term for catastrophic plans.

5 PROBLEM → Government Subsidies

Blase: The government has screwed up both the supply and demand side of the market. It restricts entry, it harms competition, and it has incentivized consolidation through various tax and subsidy policies that significantly advantage comprehensive health insurance over other ways of financing health care and over other types of expenditures. So when the government is inflating demand and restricting supply, you have a recipe for high costs and prices.

Blase: I'm concerned that the business model of insurance companies is increasingly designed around coming to this town and getting people in [the Capitol] and in the Humphrey Building more and more payment rates. I mean, that's one of my main concerns with the Obamacare and subsidy debate that we just had. The market is oversaturated in taxpayer money and to the extent the taxpayers are so on the hook for premium increases gives insurers tremendous power to further increase prices.

Emanuel: I think we do have a heavily subsidized system. I would just say you are not going to have a health care system, even if we came down to German levels of 12.5% of GDP, that isn't going to be heavily subsidized by the government. Just not possible. And this idea that somehow the government is going to get out is not tenable.

Blase: Medicaid provider taxes, which are not taxes, they're just kickbacks to fund massive corporate welfare to big hospital systems through state-directed payments. I think we need to redesign our subsidies…We could spend the same amount of money, but do it in a much more efficient way.

POTENTIAL SOLUTIONS

A "Cadillac" Tax on High Value Employer Plans

Blase: My second favorite part [of the ACA] was the Cadillac tax…but when it came up for a vote [in Congress] it was 400 to 20 in the House in favor of repealing the Cadillac tax. So there's a political problem with trying to put limits on health care spending.

Emanuel: I totally agree with you that it's wrong. We needed to cap it…I think it's absolutely important. No way it's going to happen. And I wouldn't spend any more political capital on it.

Reform 340B

Blase: I think we need to reform the 340B program. It is much bigger than anybody expected and is leading to massive amounts of consolidation. And that consolidation leads to higher prices in the market.

Emanuel: The 340B program is also a fascinating program. How did we get it? Well, Congress wanted to make sure… that poor people could get drugs, but they didn't want to pay for it. So it has this Rube Goldberg arrangement to get the drug companies to actually pay for lowering drug prices. We think [the patients] should get [the drugs] and government should pay for it, we should be honest about those payments. We don't like how high those payments are. Lower the payments. We know how to do that. Every other country in the world does it.

6 PROBLEM → Fraud in Government Programs

Blase: The fee for service, unstructured government-run programs are full of waste, fraud and abuse.

Emanuel: Is the government not careful enough about fraud? I totally agree with you. I would also mention that the fraud is almost uniformly on the provider (and health care company) side, not on the customer/patient side. We have a few episodes of fraud on the patient side, but it's insignificant compared to…organized fraud [by providers and companies].

POTENTIAL SOLUTIONS

CMS Fraud Focus

Blase: I think that there needs to be program integrity focus and this war on fraud. I think Doctor Oz is going to be the most effective CMS administrator that we have ever had… he is laser focused on protecting these programs for the vulnerable people that they were designed for.

Emanuel: That amount of savings [from all CMS planned initiatives on fraud and other payment reforms] will be in the billions of dollars, but they will be unnoticed and overwhelmed by health care inflation.

7 PROBLEM → The Cost of Medicare Advantage

Emanuel: CMS is stuck in the dark ages on risk adjustment and selection on the way they pay.

Schwartz: MedPAC estimates that Medicare spends…about $76 billion extra per year [on Medicare Advantage]. And just to contextualize that…if you care about medical research, this is more than one and a half times the NIH budget. So if you were able to kind of right size this, we could more than double the amount we're spending on cancer research, heart disease, things like that.

Schwartz: MA and traditional Medicare, they're competing together in the market…But it's really not a level playing field… MA can basically offer more to beneficiaries at lower premiums and costs…About two thirds of these plans charge no premium…that's very affordable compared to sticking in traditional Medicare…Medicare Advantage plans have out of pocket maximums…[These are] just missing in traditional Medicare…Imagine having a new cancer diagnosis and staring down the barrel of being responsible for 20% of your doctor's bills, 20% of your chemotherapy. And, oh, there's no cap. Does that seem like a very desirable product? Not very much.

Kyle: Every MA plan has a different recipe for how they're doing utilization management. It's a market, that's great, that's their secret sauce. What that means in practice is that there are dozens of forms, dozens of policies. It's hard to keep track of. This complexity ends up causing issues [for patients and providers].

Schwartz: Federal law provides a one time, six month Medigap open enrollment period at age 65. So this means you can buy…the kinds of extra protection that you would expect from a health insurance product in this day and age…but it's only for a small window, and after that, you might be priced out because of age or pre-existing conditions.

Schwartz: We pay MA plans [a monthly capitation payment] even when they get all their care at the VA. And it is not permitted for the VA to bill MA plans for this…The amount that VA is spending on health care for veterans with Medicare Advantage is rising substantially, so that it's basically at 20% of the VA's congressional appropriation.

POTENTIAL SOLUTIONS

Reforms to MA and to Traditional Medicare

Schwartz: Reforms…making traditional Medicare look like a modern insurance product, not totally unlike what you might get from an employer, would go a long way.

Schwartz: Reforms [could] ensure that Medigap is affordable beyond initial enrollment or is incorporated in the basic traditional Medicare package.

Schwartz: There's bipartisan legislation that's been introduced in committee to address [the VA/MA issue].

Blase: There are studies that show when MA penetration increases, traditional Medicare costs decline…MA disciplines providers, causing them to change their practice patterns, become more efficient, and that has spillover effects for traditional Medicare.

8 PROBLEM → Politics

Emanuel: One of our problems is we've got too much money at stake by every decision Congress and CMS make. And that's just the wrong way to organize an army. It's just not going to fix itself.

Blase: We allocate health care resources in the US increasingly on political power, not on the ability to serve patients. So I'm very concerned about increased power in this town and centralization that comes from having the best lobbyists rather than from best meeting patient needs.

POTENTIAL SOLUTIONS

Bi-Partisan Approaches

Blase: There's a set of bipartisan agreements which is going to involve taking on the health care industry because the health care industry is very powerful — the incumbent hospitals and insurance companies in particular.