Weekly Checkup

# Ask Better Questions: Three Health Care Misconceptions

LAURA HOBBS | MAY 17, 2024

**This is my last week at the American Action Forum, and for my final Weekly Checkup, I'd like to explore three exceedingly common misconceptions about health care.** I've spent over a decade in government roles, trade associations, and pharmacy services companies exploring the complex web of incentives that drive state and federal reform at warp speed. In short, there are many nuances to health care policy – much of which, it seems, those on both the left and right often fail to grasp. Before addressing health care issues, we need to ask better questions about how to best reform our health care system. And **without better questions from conservative policymakers, the likelihood of the left leading the conversation on health policy will be higher. A good place to start is by dispelling three of the biggest current misconceptions about health care held on Capitol Hill**: (1) price controls work to keep drug costs low, (2) the health care sector is full of bad actors that require increased government scrutiny to protect patients and providers, and (3) s*trict state regulation of insurance protects patient health and ensures fair contracting terms for pharmacies and other medical providers*.

Misconception One: Price controls work to keep drug costs low.

**Perhaps the oldest misconception about health care policy is that high drug prices can be remedied by simply capping them at a preferred number, without regard for supply or demand. The purest distillation of this logic can be found in the Inflation Reduction Act** (IRA), which contains several drug pricing reforms and applies an extensive program redesign placing more of the financial risk onto health plans. The left has touted this law as the best lever to reduce drug spending, mainly through its involuntary direct negotiations with manufacturers – read: price caps – and increased inflationary rebates in Medicare Parts B and D. Yet the first 10 drugs selected for negotiation by the Centers for Medicare and Medicaid Services were not even the most expensive drugs, just the most *utilized* (not that the former would have been a better selection indicator, anyway). **The IRA's price caps have other problems, too, having now incentivized drug manufacturers to set high list prices to reduce the risk of future inflationary penalties while decreasing their investment in innovative products likely to be selected for direct negotiation.** Moreover, health plans are incentivized to restrict patient access to medications that are expensive to the plan, setting-up a scenario that a patient's out-of-pocket costs will be higher under the IRA (as most beneficiaries are unlikely to hit the $2,000 yearly maximum). Finally, seniors are likely to see an increase in premium costs as health plans absorb the additional financial risk associated with the plan redesign, regardless of the 6 percent cap on premium increases starting January 1, 2024.

Misconception Two: The health care sector is full of bad actors that require increased government scrutiny to protect patients and providers.

**Across both sides of the aisle, lawmakers make overly simplistic accusations alleging that the health care sector is saturated with bad actors that prey upon patients and providers. And, more often than not, that is because lawmakers misunderstand the role these actors play** and, more frequently, fail to recognize that many of their own regulations contributed to the dysfunctional ways in which the health care sector operates.

**Hospitals, insurance companies, and drug manufacturers have all been the villains in our narrative at various times, but the bad guys of the health care sector *du jour* for both the left and the right are pharmacy benefit managers (PBMs).** PBMs are typically depicted as a malignant influence in the pharmaceutical supply chain, and thus the prevailing assumption is that passing federal and state reforms to either modify PBMs' incentive structure or require transparency into PBM private business contracts will decrease drug prices. These proposals may very well increase costs to either the health plan or the employer, and ultimately, the taxpayer or the beneficiary.

Misconception Three: Strict state regulation of insurance protects patient health and ensures fair contracting terms for pharmacies and other medical providers.

A little bit wonky and easily overlooked – but fundamental to U.S. health care insurance market – is federal protection of the health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). **ERISA provides a single, uniform framework to large and multi-state employers, thus preempting, or preventing, states from requiring employers to follow countless state regulations or benefit mandates.** The majority of Americans, approximately 153 million nonelderly adults, received health insurance from employers, with 65 percent of workers (approximately 100 million) receiving coverage governed by ERISA in 2021. After the Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Association*, many lawmakers, insurance commissioners, and attorneys general began chipping away at ERISA's preemption, having interpreted the ruling as legal permission to take legislative and regulatory action against ERISA-governed plans **. The result of state meddling in insurance markets? Employers will face an increasingly complex web of state laws and administrative costs, reducing their ability to offer competitive health care benefits.** In the long-term, employers may not offer meaningful health care coverage or employ individuals outside a single state.

**What do all these misconceptions have in common? They all suppose the health care sector simply suffers from a lack of regulation. On the contrary, the U.S. health care system is one of the most heavily regulated areas in American life**, and some of these regulations have created conflicting incentives that frequently impede the delivery of front-line health care services.

Although these reforms are well-meaning and generally are driven by a sense of correcting unfair business practices or improving patient access, they too often achieve neither goal. Conservative policymakers must resist the temptation to copy the left's tactics in using the power of the government, through increased regulatory scrutiny, to attempt to further micromanage the health care sector. If they cannot, **lawmakers will ultimately slow walk the country into a variation of universal Medicare or Medicaid, borne out of rushed, hodge-podge policies whose authors did not ask the right questions at the right time.**