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Robert J. Samuelson: How to fix health care in America

By Robert J. Samuelson Washington Post Writers Group 10 hrs ago

WASHINGTON — No doubt about it: Health care is a vexing political problem.

There's a contradiction at the core of our thinking. We want the best care when we or loved ones get sick. It's a moral issue. There should be no limits on treatment. But the resulting uncontrolled health spending harms the country. It undermines other priorities — higher wages (more labor income gets channeled into health-insurance premiums) and competent government (defense and other programs may be underfunded).

By and large, Americans ignore the contradiction. Presidents and Congresses have wrestled with it for decades without subduing it. The stakes are huge. Collectively, major federal health programs now constitute the budget's largest spending item, more than $1 trillion in 2017, or 26 percent of outlays. In 1990, the comparable figures were $137 billion and 11 percent of outlays. Meanwhile, insurance premiums — often paid by employers — have jumped, as have deductibles.

What can be done?

Based on past experience, it's tempting to say, "not much." This may ultimately be the case. But a growing number of studies suggest some cause for optimism; health costs can be contained.

The relevant studies compare Medicare reimbursement rates with private insurance payments for the same medical conditions. The finding: Medicare pays less — much less. A 2017 Congressional Budget Office study found that Medicare's average payment for a standardized hospital admission was $11,354 — 47 percent lower than insurers' $21,433.

This research has two interpretations. One is that Medicare rates have been cut to artificially low levels. To replace lost revenues, doctors and hospitals must raise their charges on privately insured patients. The increases are passed along in higher premiums. There's massive cross-subsidization of Medicare recipients by the working-age population.

Not surprisingly, the rival explanation denies Medicare's role in boosting premiums. Instead, providers — mainly doctors and hospitals — get the blame. Their market power has increased. Hospitals have merged. Doctors' group practices have grown larger or been sold to hospitals. Providers and insurance companies typically renegotiate premiums once a year. The fewer providers there are, the harder it is for insurance companies to dictate terms to the survivors.

Probably both theories contain some truth. But scholarly opinion seems to favor the market-power explanation. Significantly, the congressionally created Medicare Payment Advisory Commission (MedPac) has endorsed that view.

Many health care experts believe that high prices — hospital and doctors' charges — as opposed to more utilization of medical services are the main reason that U.S. health spending outstrips costs in other advanced societies, says Miriam J. Laugesen of Columbia University's School of Public Health and author of "Fixing Medical Prices: How Physicians Are Paid."

You can see where this is going. If higher American health spending reflects the growing market power of providers, then why not curb that power with some form of price controls? This is what most affluent societies do, notes Laugesen.

Writing in the liberal Washington Monthly magazine, Paul Hewitt and Phillip Longman recommend just that. Under their proposal, Congress would adopt the Medicare fee and reimbursement system for the entire country. If this were done, employer-paid premiums would drop sharply, and some savings — maybe all — would be passed along to workers. (Hewitt and Longman call their proposal the "single-price system," as opposed to the "single-payer system," which is universal coverage.)

Of course, this wouldn't be done instantly. The sudden loss of so much income would doubtlessly bankrupt scores of hospitals and doctors' practices, whose costs are tied to present premiums. But phased in over, say, a decade, some sort of new system might achieve significant savings without destroying the health care infrastructure.

We ought to be grappling with these issues. We aren't, for understandable if not commendable reasons. The relentless controversy over the Affordable Care Act ("Obamacare") reminds us how incendiary health care debates become, raising — as they do — issues of life and death.

There's also the reality that the self-interest of medical providers is mixed inexorably with their professional opinions. If price controls were proposed, doctors might well lose. They would surely raise legitimate questions about quality of care. Controls would also be denounced as inflexible and un-American, despite the fact that Medicare already has controls: The roughly 750 "Diagnosis-Related Groups" (DRGs) through which payments are made for various ailments and injuries.

There are few genuine solutions to our health care problems — only changes that are less bad than the alternatives. We need to slow medical spending and relax the pressures on wages and other government programs. The recognition of the huge gap between Medicare and private reimbursement rates creates the opportunity to do that. We should take it.