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The business interests behind America's costly medical care

By Dr. Philip Caper, Special to the BDN
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The United States spends far more on medical care than other wealthy countries, due mostly to higher prices for health care goods and services. There is a reason for this. In U.S. politics, social progress comes at a high price if it threatens business interests.

In 1965, at the insistence of the American Medical Association, Lyndon B. Johnson agreed to insert language into the Medicare law that prohibited the government from interfering in the practice of medicine, and assuring doctors that they would continue to receive their usual, customary and reasonable fees.

In creating the Medicare prescription drug benefit in 2003, Congress inserted a provision prohibiting Medicare from negotiating prices for drugs to placate pharmaceutical companies, costing the government billions of dollars.

In 2009, with the Affordable Care Act, the political price paid for expanding access to federally funded health care was coercing young and healthy Americans to buy private health insurance and directing billions of federal dollars to subsidies for private insurance companies. Not satisfied with that, pharmaceutical and medical device manufacturers insisted on weakening cost controls. Even the modest tax on medical devices and supplies included to help pay for the law is very likely to be repealed, with support from both parties, to mollify medical device manufacturers.

The complexity of the ACA and the poor quality of some of the most popular coverage has created new business opportunities. Accounting firms are now jumping into the fray, offering their services as tax advisers and consultants to help folks navigate their way through the ACA maze. The ongoing shift in the burden of health-care costs from insurance companies to individuals through larger out-of-pocket payments creates new opportunities for banks to offer credit card services for medical debt, often at usurious levels of fees and interest. All of this further raises health-care costs.

Unlike most other wealthy countries, the U.S. lacks any central mechanism to constrain overall health-care spending. This has led us instead to rely on piecemeal, half-hearted and largely ineffective regulation of fees by Medicare, and micromanagement of medical decision-making by private insurers at a level unheard of, and that would not be tolerated in other wealthy countries.

Those attempts at health care cost control have failed.

When government requires individuals and businesses to purchase private health insurance, it must also assure that insurance costs remain affordable, or the law will unravel. The federal government will soon have to abandon its "hands off" approach to restraining the overall costs of medical care. Every country that has moved toward making health care a human right as a matter of public policy has quickly turned its attention to ways to control its overall costs, private as well as public.

We're already seeing more attention being paid by government, the media, and professional organizations not only to the prices charged by health-care providers, but to ways to restrain the use of unnecessary services and

administrative costs, fraud, waste and abuse, and preventing illness in the first place. It should come as no surprise that Medicare data about payments to doctors has recently been released showing some very large payouts, and huge variations across the country. Although this data is incomplete and should be treated cautiously, it raises troubling questions.

The ACA is a work in progress. There is almost universal agreement that it has to be fixed, but plenty of disagreement about how to fix it. The architects of the law anticipated that likelihood. Section 1332 of the ACA provides great latitude for future experimentation by states, beginning in 2017. It allows them to discard most of the ACA's key requirements if they can come up with something better at no additional cost.

Vermont has already taken a number of important steps toward replacing the ACA with a single-payer system. Such a system would allow them to expand coverage to everybody, reduce total spending, and restrain the growth of future health-care costs to a sustainable level through budgeting.

Earlier this month, the Maine Legislature passed a resolve by a wide bipartisan margin that takes the first step toward following Vermont's example. The handwriting is on the wall. If the Legislature is unable to effectively deal with this problem, we in Maine can always express ourselves through a ballot initiative.

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