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GUEST ESSAY

$27,000 a Year for Health Insurance. How Can We Afford That?

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The debate over whether to extend the expanded Affordable Care Act subsidies has consumed lawmakers over the past two months, precipitated a government shutdown and sparked Republican infighting. Unfortunately, it's the wrong debate.

While I believe we should extend the subsidies, which expire at the end of the month, to help families pay their insurance premiums, doing so wouldn't fix the underlying problem: surging health care spending. That's the reason we need the subsidies in the first place, and it's bankrupting families and shredding jobs for low- and middle-income workers across the economy.

Just how bad is it? The best evidence we have shows that rising health spending in the United States since 1975 can explain roughly the same share of the growth in income inequality as increased trade, outsourcing or automation. It has pushed down wages, fueled inequality and left families drowning in unaffordable medical bills. Rising health care spending is killing the American dream.

Despite devastating out-of-pocket costs, Americans are generally insulated from the true cost of health care premiums. However, the expiring subsidies on the Affordable Care Act marketplaces, where more than 20 million Americans get their insurance, show just how exorbitant premiums have become. Consider a 60-year-old couple earning $85,000 a year. Without subsidies, their health insurance premiums next year will approach $32,000 (akin to buying a new Toyota Camry).

Those of us who get health care insurance from our employers — some 160 million Americans — may be breathing a sigh of relief. But our health care premiums are also staggering (an average of $27,000 a year for a family of four), and the fact that our employers pay part of the tab isn't much of a reprieve.

That's because decades' worth of research shows that, even though employers pay most of workers' premiums, those costs are passed on to workers in the form of lower wages and fewer jobs. That's why the rise in health spending above the rate of inflation over the past decade has depressed wages by nearly 10 percent, according to my calculations. And because premiums are a bigger share of total pay for lower-income workers, the job cuts triggered by rising health care spending fall disproportionally on low- and middle-income workers and fuel income inequality.

Americans spend more on health care than other countries because we pay higher prices for identical goods and services, are quicker to adopt new and costly medical technology (whether or not it is cost effective) and have higher administrative costs in our complex, decentralized system. Health care markets have consolidated so much that in many regions, hospitals and other providers can charge near-monopoly prices. The fact that we pay providers per service delivered (rather than a fixed salary) also plays a role.

Next year insurance premiums will increase 10 percent for employer-sponsored plans and 18 percent for individual plans on the exchanges compared with 2025. In both markets, they're going up because the price of medical care is rising (think hospital mergers, staffing shortages and tariffs that make drugs and devices more expensive) and Americans are increasingly using expensive weight loss and diabetes drugs known as GLP-1s. The exchange plans are seeing a sharper increase than employer plans because of the uncertainty lawmakers created over whether the Affordable Care Act subsidies would be extended. Insurers had to factor in the risk that healthier people would be less likely to buy insurance if the subsidies expired, which would lead to a sicker insurance risk pool and higher costs.

I wish there were a simple way to lower U.S. health spending. It's easy to come up with ideas for what a better health system would look like if we could start from scratch. Unfortunately, the sheer scale of our system (if the U.S. health system were a country, in dollar terms, it would be the third-largest economy in the world) means there are no silver bullet solutions. Reform involves trade-offs. One person's health care spending is another person's health care income — profits, jobs and paychecks for the tens of millions of people who work in the health care sector. And some higher spending does lead to better care. As long as they're in competitive markets, higher-priced hospitals deliver higher quality care. Slowing health spending would create winners and losers, which makes the politics of reform tricky.

If America is serious about lowering health spending, lawmakers need to pursue three paths of reform in parallel. First, we should fix existing policies that are plainly inefficient. For example, as a result of Medicare payment rules created in the 1980s, the government program pays more (sometimes double) for care delivered in a hospital or hospital-owned doctor's practice versus in an independent doctor-owned practice, even if the care is identical. That makes it more profitable for doctors to merge their practice with hospitals than remain independent. These mergers give doctors and hospitals bargaining power and drive up prices and insurance premiums. To its credit, the Trump administration

recently introduced policies that could save $10 billion over the next decade by requiring Medicare to pay hospitals the same rate they pay physicians to administer drugs, such as chemotherapy.

Second, there are numerous meaningful reforms that don't involve wholesale change and could be introduced now. I run a project called the 1% Steps for Health Reform that identifies discrete interventions that could lower the cost of health care without adversely affecting quality. Enacting 10 reforms, each of which could lower health spending about 1 percent or less, would together have a big impact: more than $250 billion annually, substantially greater than the budget of the Department of Homeland Security. One such reform is to make it easier for people to donate kidneys — which would improve recipients' health and save billions of dollars in Medicare spending on dialysis.

Finally, policymakers should explore the design and feasibility of larger structural reforms to the U.S. health system that could be introduced over a decade. These ideas include decoupling health insurance from employment, broadly regulating the prices hospitals and other providers negotiate with insurers, creating a very basic, but universal insurance coverage program and, yes, even Medicare for all. It is not enough, however, to describe what an idealized U.S. health system would look like. Serious exploration requires tangible solutions that are politically feasible and won't tank the economy.

During the government shutdown, one idea that briefly surfaced was a bipartisan commission to study ways to lower health care spending. That commission shouldn't be a footnote; it's essential. At the same time, the real pain families are feeling requires extending the expanded Affordable Care Act subsidies, at least temporarily. Americans have high premiums because elected officials have ducked the tough choices needed to rein in spending. Lower- and middle-income people shouldn't be stuck paying for that failure. But subsidies alone aren't a solution; they simply buy us time. The point is to use that time to build a system in which coverage is affordable because care is affordable. That would take political courage and an American public willing to reward leaders who choose to compromise and work together.

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