What Comes Next?
US Health Policy After King v. Burwell

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Introduction

• The primary goal of the Affordable Care Act was to expand health insurance coverage
  – It has done so, and King v. Burwell ends challenges to a major component of the ACA
  – Coverage challenges remain
    • Medicaid expansions
    • Limits of the ACA: millions of Americans who will remain uninsured
• Unlikely there will be major additional coverage policy initiatives
• Now it’s time to focus on the supply side: spending, prices, quality
  – The ACA has components aimed at these things
  – But more is required
  – Spending may be ticking up
    • Whether this time is “real” or not, growth will likely resume
Health Care Spending Not a New Problem

by Andy Warhol
(Pittsburgh native, CMU ‘49)
~ 1985-86
was available via Christie’s
$15-20,000
Health Care Cost Growth 1961-2014

National Health Expenditures Annual Growth Rate

Year

Percentage Change

2014; 5.6%

2013; 3.6%

2007; 6.4%

2014; 3.6%
Policies: Demand or Supply?

- Demand side policies/”shopping”
  - Cost sharing
    - High deductible plans
    - Reference pricing
    - Tiered/Narrow networks
  - Transparency
  - Empowerment
- These are fine, but not realistic to expect them to drive change by themselves
  - Those with very high expenses
    - “20/80 rule”
    - Risk protection
  - Information/understanding/biases
  - Powerful provider incentives
    - Payment
    - Market power
- Need to focus on the supply side
Supply Side Policies

- Two categories of critical supply side policies
  - Payment policy
  - Competition policy

- Payment policy
  - Use payment incentives to induce providers to “do the right thing”
    - E.g., bundled payments, ACOs, patient centered medical homes, capitation, bonuses/penalties, value based care, pay for performance,...

- Competition policy
  - Use market incentives to induce providers to “do the right thing”
    - E.g., antitrust, state rules and regulations, federal rules, regulations, payment policy,...

- Payment and competition policies can work
  - Make things better
  - Don’t expect 1st best: this isn’t a market for paper clips
Payment & Competition Policies

• There has been a great deal of focus on payment policy
  – Relatively little attention to competition policy

• Competition policy important in its own right
  – US has a market based health care system
  – If markets don’t function well health reform won’t work
  – Markets matter for Medicare, Medicaid beneficiaries, not just for the privately insured
Payment & Competition Policies are Complements

- **Payment reform won’t work well if there’s little or no competition.**
  - A dominant provider can simply refuse to accept a new payment model (from a private payer), and they do
  - A provider with market power will negotiate higher payments/more advantageous terms, no matter the form of payment
    - If the payment is too high/advantageous, then there’s little or no incentive to do better
  - Payments can’t do it all – competition serves to discipline behavior
    - Medicare - quality
- **Competition will work better if payments have better incentives**
  - Competition can’t do it all – payments provide incentives to focus on right areas
  - Competition doesn’t necessarily lead to right/best outcomes
  - Payments can “expand set of competitors”
    - National standards
    - Centers of excellence – competing for contracts
Competition Policy
Making Markets Work

• Policy levers – many players
  – Antitrust enforcement (FTC, DOJ, States, CMS?)
    • Keep going (provider mergers, insurance mergers, pharma mergers, payments)
    • New approaches/foci
      – Cross-market mergers
        » Geographic, Product [DOJ: Time Warner-Comcast]
      – Vertical mergers
      – Impacts on Medicare beneficiaries/CMS involvement
  – Advocacy/information
  – Consumer protection
    • Surprise out of network bills
    • Network information
    • Patient EHR
  – Federal agencies (HHS, CMS, FDA,...)
    • Network adequacy requirements
    • Surprise out of network bills
    • Reference pricing
    • Biologics naming convention
    • Licensing/regulation
  – Increased state activity/scrutiny
    • Licensing/scope of practice
    • Regs/rules: any willing provider/narrow networks; CON,...
    • Monitoring (MA HPC; TX ACO review)
    • Antitrust enforcement
    • Transparency
Conclusion

• Expanding insurance coverage has been a critical social goal
  – The ACA has achieved a great deal
  – More remains to be done, but major policy change is unlikely
• It’s time to focus on the supply side
• Payment policy and competition policy are complements
• Competition policy has not received enough emphasis
  – States and Federal agencies have important roles to play
• There is, and will be, strong push back against stronger incentives and tougher competition
  – Often at the state level
  – Must not let those efforts succeed
Cost Growth Cycles

• Reasons for cycles not entirely clear
  – Business cycle
  – Attempts to control costs followed by attempts to undo them
    • Political economy
    • Private efforts: “gaming” the system
      – Patients, hospitals, doctors,…
    • 1970s: wage & price controls (Nixon); “voluntary effort” (Carter)
    • 1980s: prospective payment system (Reagan)
    • 1990s: managed care
    • Parallel phenomena in other countries
International Growth in Health Spending, 2000-2011

Health expenditure as a share of GDP, 2000-11