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FUNDAMENTALS OF U.S. HEALTH POLICY

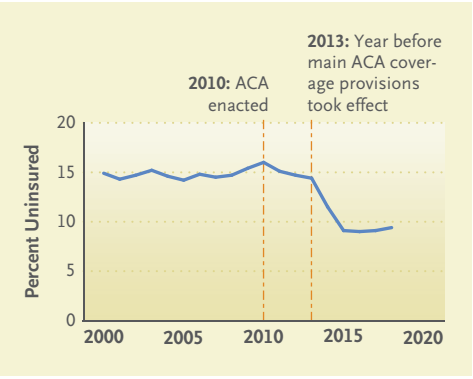
Competing Visions for the Future of Health Policy

Matthew Fiedler, Ph.D.

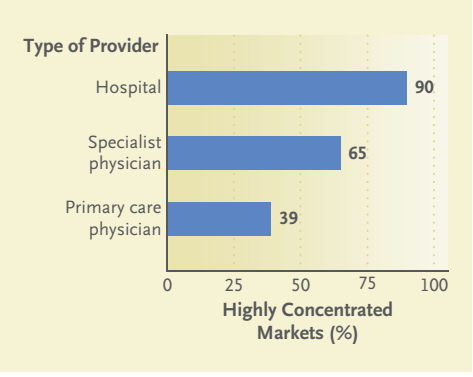
There is broad agreement that policy changes could improve the U.S. health care system. But that is often where agreement ends, and different policymakers have starkly different visions for how policy should change. While Covid-19 is dominating policy discussions for now, two other health care policy issues are still poised to feature prominently in the 2020 U.S. elections: what role government should play in ensuring broad health insurance coverage and how to cope with the lack of competition in many health care provider markets.

To understand current U.S. debates over health insurance, the first step is to recognize that there is no consensus about what problem policymakers should aim to solve — a gap that reflects both different assessments of the facts and, probably more important, differences in values. At the risk of oversimplifying, there are two broad camps. The first holds that federal policy should aim for universal coverage and deeply subsidize coverage for low- and moderate-income people, a position that reflects judgments that health insurance substantially improves health and financial security, that improving the financial well-being of lower-income people is particularly important, and that governments should have broad latitude to intervene in the health care system to improve their citizens' well-being. Policymakers in the second camp generally disagree with each of these judgments, at least to some degree, and believe that even existing federal coverage programs, particularly those serving lower-income people, are too expansive.

Policymakers in the first camp have generally supported one of two broad policy approaches. The first seeks to fill the gaps in the United States' current patchwork coverage system while preserving its overall structure, effectively continuing the approach taken under the Affordable Care Act (ACA), which drove a large decline in the uninsured rate over the past decade (see line graph).[1] These approaches would make coverage more affordable for people who currently lack it, including by encouraging all states to expand their Medicaid programs under the ACA to cover all low-income adults (or creating alternative mechanisms to cover this group) and by expanding the ACA's subsidies for people who purchase coverage on the individual market. They would also seek to ensure that people actually enroll in coverage for which they are eligible, through streamlined enrollment procedures and, in some cases, automatic enroll-



U.S. Uninsured Rate, 2000–2018.
Data are from the National Health Interview Survey.



Percent of U.S. Metropolitan Statistical Areas with Highly Concentrated Health Care Markets, 2016.
Estimates reflect the share of metropolitan statistical areas for which the Herfindahl–Hirschman Index for the specific provider type exceeds 2500, the threshold above which a market is considered highly concentrated under the horizontal merger guidelines promulgated by the Federal Trade Commission and the Department of Justice. Data are from Fulton.[2]

ment. Democratic presidential nominee Joe Biden has adopted this basic approach to expanding coverage, although the form of autoenrollment in his plan would fall short of achieving universal coverage.

Others in the first camp have supported instead replacing the current U.S. coverage patchwork with a single integrated coverage program financed entirely by tax dollars. Many proposals in this vein, including the one from Senator Bernie Sanders (I-VT), would enroll everyone in a government-run plan with minimal cost sharing, but such a program could in principle include cost sharing or allow a choice of private plans. Relative to approaches to expanding coverage that maintain the current U.S. patchwork of coverage types, this type of system would most likely be simpler and thus impose smaller administrative and hassle costs on patients and health care providers, but it would require the federal government to collect much more revenue and would involve much greater disruption to existing coverage arrangements. Proposals eliminating a role for private insurers would be particularly simple but would forfeit any benefits that may flow from innovation by private insurers in areas such as benefit design or utilization management.

By contrast, the Trump administration's policy agenda places it squarely in the second camp. As the president entered office, his administration supported legislation that would repeal or sharply curtail many of the ACA's coverage provisions, including its Medicaid expansion, subsidies for obtaining coverage on the individual market, and the mandate that all individuals obtain insurance, while also reducing eligibility and funding for the pre-ACA Medicaid program. The Congressional Budget Office concluded that several proposals the administration supported would have increased the number of uninsured by more than 20 million, thereby returning the uninsured rate to roughly its pre-ACA level, and would have substantially reduced federal spending. Although only the individual mandate was ultimately repealed, the Trump administration has included similar proposals in its annual budgets and is asking the U.S. Supreme Court to strike down the entire ACA in a case being heard this fall.

Another pressing policy question is how to cope with the fact that many regional health care markets are dominated by a small number of providers. Such domination is particularly common in hospital markets, 90% of which would be considered highly concentrated under federal guidelines for evaluating mergers, but many physician markets, particularly specialty physician markets, are also highly concentrated (see bar graph).[2] Limited competition allows providers to demand high prices from private insurers, which directly burdens enrollees in private insurance plans, may encourage providers to operate inefficiently, and can reduce quality for all patients by reducing the pressure to improve quality that comes from patients' ability to switch providers.[3]

One approach to this problem is to try to increase competition.[4] An important step would be to enhance scrutiny of mergers and anticompetitive behavior by giving antitrust agencies additional funding and expanded legal authorities. State policymakers could also eliminate policies that weaken competition, such as certificate-of-need requirements that make it harder for new providers to enter markets and "any willing provider" requirements that keep insurers from offering providers increased volume in exchange for lower prices. Many policymakers also support measures to make the prices that providers negotiate with insurers more transparent, something the Trump administration is pursuing by means of executive action, in hopes of encouraging patients to seek out lower-priced providers and encouraging providers to price more competitively, although prior ex-

perience with price transparency is uneven.[5]

Policies designed to enhance competition are attractive because they have few downsides and garner support in both parties (although generally not from the health care providers who benefit from high prices). But these approaches have limitations. Enhancing antitrust enforcement may be less effective in the many markets in which one or a few providers already hold dominant positions. In addition, robust competition may not be realistic (or even desirable) in some smaller markets, given the fixed costs associated with operating another hospital or physician practice.

Policymakers may therefore wish to consider policies that could reduce prices even where competition is limited. Such policies could include directly capping prices — for example, at some percentage of Medicare rates. Alternatively, policymakers could create a "public option" that would pay prices similar to Medicare's and compete alongside private plans, which could reduce prices directly but also give private insurers leverage to extract lower prices from providers. Biden supports creating a public option, whereas the Trump administration has almost uniformly opposed approaches that expand the public role in determining health care prices.

An audio interview with Dr. Fiedler is available at NEJM.org

Policies like these could drive prices lower than policies that aim only to enhance competition, but they also have greater potential downsides. Notably, whereas enhancing competition could strengthen providers' incentives to improve quality, these policies could weaken those incentives by reducing providers' ability to parlay investments in quality into higher prices or lucrative new volume, although the magnitude of this effect is uncertain. In light of the burdens that high prices place on patients, these policies may still be worth pursuing even if they do reduce quality to some degree, but policymakers should be mindful of this trade-off when deciding whether and how aggressively to use these tools.

In the near term, Covid-19 may push some of the debates considered here into the background. Others may loom larger. Indeed, Covid-19 has highlighted both the benefits of the ACA's coverage programs for people without job-based coverage and the remaining gaps in the U.S. health insurance system. Regardless, in light of the deep differences among 2020 candidates, voters' choices this fall — whether driven by health care or other issues — will shape the health care system for years to come.

Disclosure forms provided by the author are available at NEJM.org.

From the USC–Brookings Schaeffer Initiative for Health Policy, Brookings Institution, Washington, DC.

1. Fiedler M, Aaron HJ, Adler L, Ginsburg PB, Young CL. Building on the ACA to achieve universal coverage. N Engl J Med 2019;380:1685-8.
2. Fulton BD. Health care market concentration trends in the United States: evidence and policy responses. Health Aff (Millwood) 2017;36:1530-8.
3. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? Hospital prices and health spending on the privately insured. Q J Econ 2019;134:51-107.
4. Gaynor M. What to do about health-care markets? Policies to make health-care markets work. The Hamilton Project, March 10, 2020 (https://www.hamiltonproject.org/papers/what_to_do_about_health_care_markets_policies_to_make_health_care_markets_work).
5. Benavidez G, Frakt A. Price transparency in health care has been disappointing, but it doesn't have to be. JAMA 2019;322:1243-4.

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Assessing the Safety of Glucose-Lowering Drugs — A New Focus for the FDA

William H. Chong, M.D., Lisa B. Yanoff, M.D., Eugenio Andraca-Carrera, Ph.D., and Mary Thanh Hai, M.D.

Patients with type 2 diabetes mellitus in the United States are a large and growing population. These patients are at risk for serious complications of their disease and often have multiple coexisting medical conditions. Many need lifelong treatment with medications, including glucose-lowering drugs. For more than a decade, the Food and Drug Administration (FDA) has urged pharmaceutical companies to demonstrate that new drugs developed to improve glycemic control in patients with type 2 diabetes don't pose an unacceptable risk of ischemic cardiovascular events.[1] The focus on major adverse cardiovascular events (MACE) emerged from concerns that were raised about the effect of glucose-lowering therapies on cardiovascular morbidity and mortality, including a finding of an increased risk of myocardial infarction and cardiovascular death associated with rosiglitazone in a meta-analysis of 42 trials.[2] Having spent the past decade focused on