Weekly Checkup

Who's Making Health Policy?

CHRISTOPHER HOLT | OCTOBER 11, 2019

This week saw more executive action on health care from the Trump Administration, as the Department of Health and Human Services (HHS) published two notices of proposed rulemaking related to promoting value-based care arrangements. **The notices are important, but what they signal about the nature of health policymaking right now is perhaps more noteworthy:** The political realities of this divided Congress and its conflict-heavy relationship with the Trump Administration mean that **the executive branch will be the center of health policymaking for the foreseeable future.**

First, however, let's consider the proposed rules. **Federal anti-kickback and self-referral statues have proven to be a barrier to coordinating care in federal health programs and to rewarding quality in payment systems, and both rules address this problem.** The first comes from the Centers for Medicare and Medicaid Services and would establish new exemptions to federal Stark Laws for value-based arrangements. The Stark Laws (named for former Congressman Pete Stark) were established to prevent self-dealing by providers in federal heath care programs. The second proposed rule is out of the HHS Office of Inspector General and would create half a dozen new safe harbors from federal anti-kickback laws and modify or expand another half dozen existing safe harbors. The purpose here again is to remove obstacles to value-based care arrangements. While some details of both regulations may be debatable, the overall aim here isn't terribly controversial. Of course, these are only proposed rules—with comments due by the end of the year—and would have to be finalized to have an effect.

Stepping back, a regular reader of the Weekly Checkup might notice a trend: There are Weekly Checkups dealing with Trump Administration actions (see last week's edition), and Weekly Checkups looking at congressional legislative efforts that never seem to come to fruition. I argued after the 2018 election that the impact wouldn't be terribly substantial on health policymaking because the 115th Congress had already accomplished most of what it could agree on under unified party control, and in general health policymaking had been shifting to the executive branch for some time. The Democratic takeover of the House, and resulting divided government, would simply encourage even more the executive to act unilaterally.

This shift didn't originate with the Trump Administration (lest we forget, "I've got a pen and a phone"), but the trend is accelerating, and Congress's cession of power is concerning. A search of Congress.gov for the term "health" returns seven enacted pieces of legislation in the 116th Congress—including S.2047, a bill "to provide for a 2-week extension of the Medicaid community mental health services demonstration program, and for other purposes." Congress may not be acting, but it has the responsibility under the Constitution to set the course of federal policy. Its inability to legislate has increasingly shifted policymaking to the bureaucrats and political appointees in executive agencies.

Of course, the first session of the 116th Congress has not closed, and there is reason for hope as a result. The presidential campaign, another fight over border wall funding, and the impeachment inquiry all could derail any deal, but the possibility of bipartisan legislation on surprise medical billing and drug prices remains alive. **On both surprise medical billing and drug prices, President Trump has expressed a desire to sign legislation, and the House and Senate have been active on legislative efforts**. Congress still could address one or both of these policy challenges, likely in the end-of-year funding package, but the trend line is not

encouraging.

CHART REVIEW

Andrew Strohman, Health Care Data Analyst

A recent Journal of the American Medical Association (JAMA) article estimated that approximately 25 percent of annual health care spending — between $760 billion and $935 billion — constituted wasteful expenditures. Due to health care costs approaching 18 percent of gross domestic product (GDP), this wasteful spending accounts for 4.5 percent of GDP. These monetary values were further broken down into six categories, as shown in the chart below. Excluding administrative complexity, the authors went on to project potential savings of $191 billion to $282 billion for interventions that reduce waste. Based on this information, there are ample opportunities for research to evaluate methods of curbing excess health care costs. Consumers and taxpayers would likely receive the bulk of the savings.