WHY WE AREN’T THERE YET: HEALTH LAW CONSTRAINTS ON HEALTH POLICY SOLUTIONS

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- The opinions expressed in this presentation are the author's own and do not reflect the view of the University of Texas at Austin or the State of Texas.
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• The opinions expressed in this presentation are the author's own and do not reflect the view of the University of Texas at Austin or the State of Texas.

• The author is a registered Democrat and a strong supporter of the Affordable Care Act.

• The author believes that market competition lowers prices, improves quality, and boosts innovation.

• The author would like the US to stop wasting $1,000,000,000,000 each year churning overpriced, often useless services and medicalizing social problems.
HAVING IT ALL: 
THE ACA’S SWEEPING POLICY GOALS FOR 
INSURANCE, HEALTH CARE AND HEALTH

• Title I: “Quality, Affordable Care for All Americans”
  • Insurability reforms
• Title II: “Role of Public Programs”
  • Affordability-of-insurance reforms
• Title III: “Improving the Quality and Efficiency of Health Care”
  • Delivery system reforms
• Title IV: “Prevention of Chronic Disease and Improving Public Health”
  • Health reforms
THE ACA SOLVES INSURANCE
(SOLUTIONS SHOWN BELOW)

• Title I: “Quality, Affordable Care for All Americans”
  • Insurability reforms

• Title II: “Role of Public Programs”
  • Affordability reforms
THE ACA FLAGS HEALTH CARE AND HEALTH (PROBLEMS SHOWN BELOW)

- Title III: “Improving the Quality and Efficiency of Health Care”
  - Delivery system reforms

- Title IV: “Prevention of Chronic Disease and Improving Public Health”
  - Health reforms
THE ACA’S EVIDENCE BASE: REFRAMING HEALTH POLICY FROM RATIONING NEW TECHNOLOGY (AND MAKING COLLECTIVE SACRIFICES)…

1. Access
2. Quality
3. Cost

*The “Iron Triangle” (of medical progress)*

“No society in the world has ever been -- or will ever be -- able to afford providing all the health services its population is capable of utilizing."

… TO REDUCING WASTE AND IMPROVING HEALTH (THEREBY HAVING MORE OF EVERYTHING)

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost of health care

- Institute for Healthcare Improvement

*The Triple Aim*
GAME-CHANGER: REVISITING REFORM STRATEGIES FROM SO FAR OFF THE PARETO FRONTIER

• Insurance competition/Health Savings Accounts
  - New coverage/benefit models vs financial “skin in the game”

• Managed competition/insurance exchanges
  - Making care efficient vs private (contractual) rationing
  - Addressing social determinants vs promoting preventive medicine

• Single-payer/Medicare-for-all
  - Restructuring payment and delivery vs. price controls and public rationing (death panels?)
  - Expanding Medicare Advantage vs constraining FFS administrative cost and profit

FOR ALL STRATEGIES: DECENTRALIZED, INCREMENTAL IMPROVEMENT MORE THAN NATIONAL (OR EVEN STATE) POLITICAL CONSENSUS
THE SLOW PURSUIT OF HEALTH CARE VALUE: WE KNOW WHERE WE NEED TO GO

Health care should be safe, effective, patient-centered, timely, efficient, and equitable

- Institute of Medicine

Crossing the Quality Chasm (2001)
THE SLOW PURSUIT OF HEALTH CARE VALUE: WE KNOW HOW TO GET THERE

• Organize into Integrated Practice Units
• Measure outcomes and costs for every patient
• Move to bundled payments for care cycles
• Integrated care delivery across separate facilities
• Expand excellent services across geography
• Build an enabling information technology platform

- Michael Porter and Thomas Lee
  
  How to Fix Health Care (2013)
SO, WHY AREN’T WE ALREADY THERE?
ACCRETED HEALTH LAW: 100 YEARS OF PRIVILEGE, REGULATION, AND SUBSIDY

- **Physician privileges**: licensing/scope of practice restrictions, prescriptive authority; other ordering and referral rules; emphasis on specialists; corporate practice prohibitions

- **Physician-hospital relations**: open medical staffs leading to fragmented co-production of complex services; corporate practice prohibitions

- **Hospitals** as “free” physician workshops and community resources, not competitive patient care businesses; tax-exemption rules; certificate of need laws

- **Employment-based private insurance**: generous tax subsidy; aggregated employee preferences; physician-oriented benefit design; early restrictions on selective contracting

- **Medicare**: non-interference with medical practice; customary/cost-based “reimbursement”; separate facility and professional payment formulas; fee-for-service fraud and abuse (including fraud control)

- **Managed care backlash**: broad, unmanaged networks with substantial consumer cost-sharing

- **Stunted/distorted antitrust and consumer protection laws**
CONSEQUENCES OF ACCRETED HEALTH LAW

- Fragmented production
- Minimal price competition
- Many barriers to competitive entry (e.g., lack of non-MD primary care)
- Needlessly small geographic markets (e.g., barriers to telemedicine)
- Buyers who also sell (and take a cut)
- Automation that almost never decreases labor costs
- Little self-care
- Large insurers and large providers often “in cahoots”
- Constrained innovation (e.g., mainly drugs and medical devices that match current production processes)
- And, incoherent products!
LEGALLY CONSTRAINED HEALTH CARE PRODUCTS

• Horses: We usually buy and sell
  • Professional process steps
  • Inputs/complements to professional processes
  • Claims processing (no risk of loss to “insurer”)

• Zebras: We occasionally buy and sell
  • Comprehensive prepaid care (true HMOs)
  • Patient-directed care (informed self-help)

• Unicorns: We almost never buy and sell
  • Assembled products with warranties comparable to other complex consumer goods
WHAT ABOUT THE FRENCH FRY (HEALTH)?

• Title III: “Improving the Quality and Efficiency of Health Care”
  • Delivery system reforms

• Title IV: “Prevention of Chronic Disease and Improving Public Health”
  • Health reforms
THE ACA’S BIG OMISSION

• Title I: “Quality, Affordable Care for All Americans”
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• Title ?: The Missing Piece
  • “We’re-in-this-togetherness” (solidarity)
WE DIDN’T NEED “OBAMACARE.”
WE NEEDED “AMERICARE.”
OBESITY TRENDS* AMONG U.S. ADULTS
BRFSS, 1990
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
OBESITY TRENDS* AMONG U.S. ADULTS
BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
A YEAR OF GROCERIES AFTER WWII (W. DIETZ)
TODAY’S FOOD ENVIRONMENT
(A. GEARHARDT)
TODAY’S FOOD ENVIRONMENT (A. GEARHARDT)
POVERTY AND US HEALTH CARE SPENDING
FRACKING HEALTH CARE TO “RECOVER AND REPURPOSE” TRAPPED VALUE

FRACKING SHALE ROCK. In barely a decade, America’s most costly and least reliable economic input – energy – has been revolutionized. Not by the invention of a dramatic alternative to conventional fuels, but by the realization that domestic energy extraction had been astoundingly wasteful and incomplete. With the incentive of high oil prices and a facilitative business and legal environment, horizontal hydraulic fracturing revealed and released massive amounts of natural gas and oil that had been left trapped in shale deposits throughout the country. Though not without legitimate concerns and detractors, fracking has made energy more affordable, boosted overall economic activity, and freed the United States from dependence on foreign sources of oil and gas. These outcomes would have been thought a fantasy until they actually happened.

NOBODY THOUGHT IT COULD BE DONE. UNTIL IT WAS.

WHAT IF OUR NATION COULD SPEND THE NEXT DECADE DOING THE SAME THING WITH AMERICAN HEALTH CARE?
DISRUPTING THE LEGAL SUBSTRATE: ENGINEERS

• De-regulators and “re-regulators”
• Educators of professionals and non-professionals
• Consumer advocates
• Antitrust and anti-fraud enforcers
• Payment reformers
• Litigators
ENGINEERING RELEASE: THE TACTICS

• Eliminating Claims Middlemen
• Disintermediating Physicians
• Ending “Blank-Check” Hospitalization
• Expanding Self-Care
• Reining in Drug Costs
• Building a Flexible Workforce
• De-Medicalizing Social Problems
REAPING THE REWARDS: PROFITS AND PERILS

- **Profits**: A successful “fracking” enterprise has many payoffs for individuals, businesses, and society.
  - Cheaper health care
  - Safer health care
  - More convenient health care
  - Corporate wage growth and hiring
  - Tax cuts
  - Better education and social services
  - A new path for medical innovation, not just a forced one-time rese

- **Perils**: Local job loss/economic instability; misappropriated gains
CONCLUSION: CAN IT HAPPEN?

• The value trapped in the U.S. health care system will not stay there forever. It is already being appropriated, slowly and covertly, despite the constraints of existing regulatory and professional norms.

• Fracking shale rock, though very disruptive, was also rapid, transparent, and surprisingly democratic.

• An explicit conversation about “fracking” healthcare is an important step toward doing it well.